



**Health and Wellbeing of Intermarried Filipino Women in Rural  
Tasmania**

by

**Chona Hannah**

Bachelor of Secondary Education (Cebu Normal University)

Graduate Certificate of Education (University of Tasmania)

Master of Education (University of Tasmania)

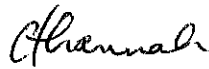
**A Thesis Submitted in Fulfilment of the Requirements of the  
Degree of Doctor of Philosophy**

**Department of Rural Health  
University of Tasmania**

**April 2012**

# Statements and Declaration

I, Chona Hannah, am the author of the thesis titled *Health and Wellbeing of Intermarried Filipino Women*, submitted for the degree of Doctor of Philosophy. I declare that the material is original, and to the best of my knowledge and belief, contains no material previously published or written by another person, except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright. The thesis contains no material which has been accepted for a degree or diploma by the University or any other institution.



Chona Hannah

30 April 2012

# Statement of Co-authorship

The following people and institutions contributed to the publication of the work undertaken as part of this thesis:

Paper 1: Hannah, C, 'Health and wellbeing of intermarried Filipino women, Graduate Research Papers in Rural Health, University of Tasmania, Quynh Le (ed), Launceston, pp. 65-82. (2007)

*Chona Hannah (100%)*

Paper 2: Hannah, C. and Le, Q, 'Health and Wellbeing Issues Facing Intermarried Filipino Women in Rural Tasmania', Health and wellbeing: A social and cultural perspective, NOVA Science Publishers Inc, Quynh Le (ed), New York, pp. 173-184. (2011)

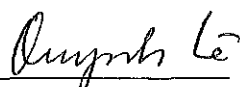
*Chona Hannah (60%), Quynh Lê (40%)*

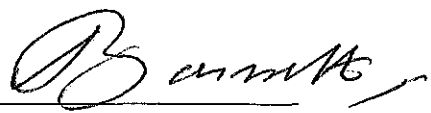
Details of the Authors roles:

*Chona Hannah: First draft of the paper, contributed to the formalisation, development and assisted on the refinement and presentation of the chapter.*

*Quynh Le: Contributed to the formalisation, assisted on the refinement and presentation of the chapter, final draft of the paper.*

We the undersigned agree with the above stated "proportion of work undertaken" for each of the above published (or submitted) peer-reviewed manuscripts contributing to this thesis:

Signed:   
Dr Quynh Le  
Supervisor  
Department of Rural Health  
University of Tasmania

Signed:   
Associate Professor Tony Barnett  
Director  
University Department of Rural Health  
University of Tasmania

Date: 01 May 2012

Date: 1 MAY 2012

## Statement of Authority of Access


I, Chona Hannah, author of the thesis title *Health and Wellbeing of Intermarried Filipino Women in Rural Tasmania*, submitted for the degree of Doctor of Philosophy, agree that this thesis may be made available for loan and limited copying and communication in accordance with the Copyright Act 1968.

  
Chona Hannah

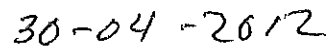
30 April 2012

# Statement of Ethical Conduct

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, and the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University.



Chona Hannah



Date

# Abstract

Intermarriage has become a social phenomenon for some Filipino women. This is particularly true in Australia, where most Filipino women have arrived on the basis of marriage. They bring with them their cultural values and beliefs which affect the way in which they view their new environment, through their cultural lenses and their views and attitudes may not be understood or accommodated by the mainstream. The main purpose of this research was to investigate the health and wellbeing of Filipino wives who came to Australia as a result of intermarriage and now live in rural parts of Tasmania. The focus was on the following aspects: acculturation problems, health concepts and health care in rural Tasmania, problems in access to health care services, and the social and cultural capital.

This study employed mixed methods with a combination of quantitative and qualitative approaches. Data analysis revealed that health and wellbeing were the two most important aspects in the life of the intermarried Filipino women in rural Tasmania. The main factors which significantly affect their health and wellbeing in their acculturation into rural Tasmania include: age gap, English language proficiency, highest level of education, and length of stay in Tasmania. The findings of this study also presented insights into the mental and emotional intelligence of the intermarried Filipino women as to how they handled possible culture shock and how they adapted to the mainstream culture throughout their interracial married life.

# Acknowledgements

This study would have not been possible without the involvement of many people to whom I would like to express my heartfelt gratitude.

My special gratitude goes first to my incomparable Chief Supervisor Dr Quynh Lê, for unselfishly sharing her expertise and knowledge, constructive feedback, and for being not just a supervisor but a friend as well. I was very fortunate to have her support throughout my PhD journey.

Secondly, I would like to express my deepest gratitude to Dr Thao Lê (co-Supervisor), whom from the start of my studies in UTAS has encouraged me to 'think big' and 'dream big'. He is one of the reasons why I have attempted this course. His words of wisdom and encouragement have inspired me and made me realise what future lies ahead of me if I pursue my studies.

Thirdly, I would like to give special thanks to Associate Professor Sue Kilpatrick for giving me the chance to be her graduate research student even for a short period of time. Her professional expertise has inspired me tremendously. Special thanks also go to Cecilia Walters, Allan Snare and Linda Sydes for proofreading my thesis chapters.

Aside from my supervisors, I also owe a big thank you to all the intermarried Filipino women who have willingly participated in my study and for welcoming me into their home as I conducted the face to face interviews. Great thanks also go to all my friends, especially Marie Clive, Corrine Allen (Filipino Australian Friends Association), Jennifer Rigby, Susan Hardy, Mr and Mrs Jim Bassett, Mrs Josie Wallace (Migrant Resource Centre) and to Mr Kerry Whittle (Bayanihan Club President) for helping me reach a good number of participants in my research.

To my University Department of Rural Health (UDRH) family especially Kim Izard and Leonie Geard, thank you for all your assistance over the past four years specifically in terms of my attendance at international conferences. Special thanks as well to

Chris McKay and Andrew Connor for all the computer support I needed. To all the staff of UTAS library in Newnham, thank you very much for your quick response to all my queries and book reservations.

To my husband, Paul Hannah, and to my two beautiful children (Billee and Elizabeth), you are my strength and my life. Thank you for all your love and support. To the Meciar family, and Hannah family, thank you so much for believing in me and for always making me feel that I have a family here in Australia. To my beloved family in the Philippines, to my dear Mama, my brothers and sisters as well as my nieces and nephews, guys you are all my inspiration.

Lastly, I give my sincerest gratitude to my God almighty. Thank you for always making me realise that in everything there is always a reason for it and for your undying love to me. Please God, let my Papa know how much I love him and that I share this achievement with him.



# Table of Contents

|   |     |
|---|-----|
| Statements and Declaration .....                | i   |
| Statement of Co-authorship .....                | i   |
| Statement of Authority of Access .....          | i   |
| Statement of Ethical Conduct .....              | i   |
| Abstract .....                                  | ii  |
| Acknowledgements.....                           | i   |
| Table of Contents .....                         | iii |
| List of Figures .....                           | vii |
| List of Tables .....                            | 11  |
| Chapter 1 – Introduction .....                  | 13  |
| 1.1. Introduction.....                          | 13  |
| 1.2. Background and rationale of research ..... | 13  |
| 1.2.1. Theoretical background .....             | 14  |
| 1.2.2. Contextual background .....              | 17  |
| 1.3. Research objectives .....                  | 21  |
| 1.4. Overview of the methodology.....           | 22  |
| 1.5. Ethical issues.....                        | 24  |
| 1.6. Significance of the study.....             | 24  |
| 1.6.1. Theoretical significance.....            | 25  |
| 1.6.2. Discourse significance .....             | 26  |
| 1.7. Limitation of research .....               | 27  |
| 1.8. Structure of the thesis .....              | 28  |
| 1.9. Conclusion .....                           | 29  |

|  |            |
|--|------------|
| <b>Chapter 2 – Literature Review .....</b>   | <b>30</b>  |
| 2.1. Introduction.....   | 30         |
| 2.2. Filipino women in interracial marriage .....                                      | 30         |
| 2.3. Intermarried Filipino women’s health issues .....                                 | 37         |
| 2.3.1. Concept, views attitude about health.....                                       | 38         |
| 2.3.2. Access to health care services.....   | 42         |
| 2.3.3. Health problems.....  | 50         |
| 2.4. Intermarried Filipino women’s wellbeing .....                                     | 54         |
| 2.4.1. Defining wellbeing.....   | 54         |
| 2.4.2. Wellbeing issues.....   | 56         |
| 2.5. Conclusion .....  | 68         |
| <b>Chapter 3 – Methodology .....</b>   | <b>70</b>  |
| 3.1. Introduction.....   | 70         |
| 3.2. Research design.....  | 70         |
| 3.2.1. Quantitative approach .....   | 77         |
| 3.2.2. Qualitative approach.....   | 83         |
| 3.3. Reliability and validity issues .....   | 89         |
| 3.3.1. Reliability in quantitative approach .....                                      | 89         |
| 3.3.2. Validity .....  | 92         |
| 3.3.3. Reliability and validity in qualitative approach .....                          | 93         |
| 3.3.4. Importance of reliability and validity in mixed method research<br>design ..... | 95         |
| 3.4. Ethical issues.....   | 97         |
| 3.5. Research limitation.....  | 99         |
| 3.6. Conclusion .....  | 100        |
| <b>Chapter 4 – Quantitative data analysis .....</b>                                    | <b>101</b> |
| 4.1. Introduction.....   | 101        |
| 4.2. Survey response rate .....  | 102        |
| 4.3. Profiles of the participants .....  | 102        |
| 4.3.1. Age group .....   | 102        |
| 4.3.2. Educational level .....   | 103        |
| 4.3.3. Location of residence .....   | 104        |
| 4.3.4. Length of stay in Tasmania.....   | 104        |
| 4.3.5. Employment status .....   | 105        |
| 4.3.6. English language proficiency.....   | 106        |
| 4.3.7. Combined household income .....   | 106        |
| 4.4. Health and wellbeing.....   | 107        |
| 4.4.1. Health concept .....  | 107        |
| 4.4.2. Access to health care services and its issues .....                             | 114        |

|  |   |            |
|--|---|------------|
| 4.4.3.   | Personal wellbeing .....  | 122        |
| 4.4.4.   | General health and wellbeing .....  | 126        |
| 4.5.   | Analysis of factors affecting the participants' views and attitudes towards their health and wellbeing and their access to health care services ..... | 131        |
| 4.5.1.   | Chi-square test of independence .....   | 131        |
| 4.5.2.   | Factors that affects the participants' views on health concepts and access to health care services .....  | 132        |
| 4.5.3.   | Factors that affect participant's personal wellbeing .....  | 136        |
| 4.5.4.   | Factor that affect participant's general health and wellbeing.....  | 141        |
| 4.6.   | Conclusion .....  | 142        |
| <b>Chapter 5 – Qualitative Data Analysis .....</b>                     |   | <b>144</b> |
| 5.1.   | Introduction .....  | 144        |
| 5.2.   | Data collection and analysis .....  | 144        |
| 5.3.   | Data analysis process.....  | 147        |
| 5.4.   | Social-demographic background of the participants .....   | 150        |
| 5.5.   | Data analysis results with the emerging themes .....  | 151        |
| 5.5.1.   | Health and wellbeing issues.....  | 151        |
| 5.5.2.   | Issues in accessing health care services.....   | 168        |
| 5.5.3.   | Coping behaviour .....  | 171        |
| 5.6.   | Conclusion .....  | 176        |
| <b>Chapter 6 – Discussion and Interpretation of Data Findings.....</b> |   | <b>178</b> |
| 6.1.   | Introduction.....   | 178        |
| 6.2.   | Acculturation problems.....   | 178        |
| 6.2.1.   | Age .....   | 179        |
| 6.2.2.   | Highest level of education.....   | 180        |
| 6.2.3.   | Length of stay in Tasmania.....   | 181        |
| 6.2.4.   | English language proficiency.....   | 183        |
| 6.3.   | Health concepts and views about health and health care in rural and regional Tasmania .....   | 184        |
| 6.3.1.   | Health matters .....  | 185        |
| 6.3.2.   | Cultural views.....   | 190        |
| 6.3.3.   | Issues in accessing health care in rural and regional Tasmania.....   | 192        |
| 6.4.   | Social and cultural capitals which enhance the wellbeing of intermarried Filipino women in rural and regional Tasmania .....                          | 194        |
| 6.4.1.   | Social support network .....  | 194        |
| 6.4.2.   | The media and the internet .....  | 195        |
| 6.5.   | Conclusion .....  | 196        |
| <b>Chapter 7 – Conclusion and Reflection .....</b>                     |   | <b>197</b> |

|                         |   |            |
|-------------------------|---|------------|
| 7.1.                    | Introduction .....  | 197        |
| 7.2.                    | Achievement of the study .....                                | 197        |
| 7.2.1.                  | Was the research successful? .....                            | 198        |
| 7.2.2.                  | What were the main findings? .....                            | 200        |
| 7.2.3.                  | How do they affect the current views of the researcher? ..... | 203        |
| 7.3.                    | Future research .....   | 205        |
| 7.4.                    | Recommendations.....  | 206        |
| 7.5.                    | Concluding statement .....                                    | 206        |
| <b>References .....</b> |   | <b>208</b> |
| <b>Appendices .....</b> |   | <b>234</b> |

# List of Figures

|  |     |
|--|-----|
| Figure 1-1: Overseas born brides marrying long-time Australians .....  | 16  |
| Figure 3-1: The flow of mixed method designs used in this study, adapted<br>from Hosler and Vesper (1993) .....                              | 76  |
| Figure 4-1: Distribution of participants by age group, n=145. ....   | 103 |
| Figure 4-2: Distribution of participants by educational level, n=145. ....   | 103 |
| Figure 4-3: Distribution of participants by location of residence in the<br>Philippines, n=145. ....   | 104 |
| Figure 4-4: Distribution of participants by length of stay in Tasmania, n=145. ....  | 105 |
| Figure 4-5: Distribution of participants by employment status, n=145. ....   | 105 |
| Figure 4-6: Distribution of the participants by English language proficiency,<br>n=145. ....   | 106 |
| Figure 4-7: Distribution of the participants by combined household income,<br>n=145. ....  | 107 |
| Figure 4-8: Participants' responses to Q9 - "I still hold traditional Filipino<br>beliefs and views in looking after my health", n=145. .... | 108 |
| Figure 4-9: Participants' responses to Q10 - "I need to know more about<br>building a healthy lifestyle. ....                                | 108 |
| Figure 4-10: Participants' responses to Q11- "The change in weather<br>conditions affect my health", n=145. ....                             | 109 |
| Figure 4-11: Participants' responses to Q12 - "Proper hygiene is a vital aspect<br>of my health", n=145. ....                                | 110 |

|  |     |
|--|-----|
| Figure 4-12: Participants' responses to Q13 - "Religion or strong faith is considered as an important aspect in having a good health", n=145.....  | 111 |
| Figure 4-13: Participants' responses to Q14 - "Healthy lifestyle is vital to my wellbeing in Australia", n=145. ....   | 111 |
| Figure 4-14: Participants' responses to Q15 - "Proper nutrition is important to my health and wellbeing", n=145.....   | 112 |
| Figure 4-15: Participants' responses to Q16 - "Physical health limits Filipino women's interaction with others", n=145. ....   | 113 |
| Figure 4-16: Participants' responses to Q17 - "The care of my family is important to me when I am sick", n=145.....  | 113 |
| Figure 4-17: Participants' responses to Q19 - "Information materials about health care services in Australia are useful on my arrival", n=145.....   | 114 |
| Figure 4-18: Participants' responses to Q20 - "Health care professionals are very approachable", n=145. ....   | 115 |
| Figure 4-19: Participants responses to Q21 - "I can usually access health care services (such as: medical care, mental health care, community health care, etc.) when I need them", n=145..... | 115 |
| Figure 4-20: Participants' responses to Q22 - "I prefer to be treated by a female doctor", n=145.....  | 116 |
| Figure 4-21: Participants' responses to Q23 - "I learned more about health care services through mass media (TV, magazines, newspaper, etc.)", n=145.....                                      | 117 |
| Figure 4-22: Participants' responses to Q24 - "The internet is helpful for searching of information about health care services", n=145.....  | 118 |
| Figure 4-23: Participants' responses to Q26 - "Health care professionals should be aware of migrants' cultural views", n=145. ....   | 119 |

|  |     |
|--|-----|
| Figure 4-24: Participants' responses to Q28 – "Information about health/health care services should be available in different languages", n=145. ....    | 120 |
| Figure 4-25: Participants' responses to Q29 – "There should be interpreting services available in all health care agencies", n=145. ....                 | 121 |
| Figure 4-26: Participants' responses to Q30 – "Being able to speak English makes it easy for Filipino women to access health care services", n=145. .... | 121 |
| Figure 4-27: Participants' responses to Q31 and Q38 – "Life as a wife", n=145. ....  | 122 |
| Figure 4-28: Participants' responses to Q32 and Q39 – "Standard of living", n=145. ....  | 123 |
| Figure 4-29: Participants' responses to Q33 and Q40 – "Your health", n=145.....  | 123 |
| Figure 4-30: Participants' responses to Q34 and Q41 – "Achievement in life", n=145. ....   | 124 |
| Figure 4-31: Participants' responses to Q35 and Q42 – "Personal relationship", n=145. ....   | 125 |
| Figure 4-32: Participants' responses to Q36 and Q43 – "How safe do you feel?", n=145. ....   | 125 |
| Figure 4-33: Participants' responses to Q37 and Q44 – "Feeling as being part of the community", n=145. ....  | 126 |
| Figure 4-34: Participants' responses to Q45 – "How often do you have body pains?" n=145.....   | 127 |
| Figure 4-35: Participants' responses to Q46 – "How often do you visit your family doctor?" n=145. ....   | 128 |
| Figure 4-36: Participants' responses to Q47 – "How often do you need to see a dentist in a year?", n=145. ....   | 128 |

**Figure 4-37: Participants’ responses to Q48 – “How often do you need to see an optician in a year”, n=145. ....129**

**Figure 4-38: Participants’ responses to Q49 – “How often do you see a psychologist in a year”, n=145. ....130**



# List of Tables

|  |     |
|--|-----|
| Table 2-1: <i>Distribution of Filipino Migrants in Australia by State/Territory</i> .....  | 34  |
| Table 2-2: <i>Filipino Community Organisations in Australia by State adapted from FILOPAGES (2008)</i> .....   | 36  |
| Table 3-1: <i>Strength and weaknesses of the three approaches to research adapted from Johnson &amp; Onwuegbuzie (2004, pp. 19-21)</i> .....   | 72  |
| Table 3-2: <i>Structure of the Questionnaire (full details in Appendix 1)</i> .....  | 79  |
| Table 4-1: <i>Chi-square test on the relationship of participant's English language proficiency and their views on the absence of Filipino food affect their diet</i> .....  | 133 |
| Table 4-2: <i>Chi-square test of the relationship between participant's English language proficiency and their views on health care professionals are very approachable</i> .....  | 133 |
| Table 4-3: <i>Chi-square test of the relationship between participant's English language proficiency and their views on health care professionals should be aware of migrants' cultural views on dealing with them</i> ..... | 134 |
| Table 4-4: <i>Chi-square test of the relationship between participant's English language proficiency and their views on internet as a helpful tool for searching information about health care services</i> .....            | 135 |
| Table 4-5: <i>Chi-square test of the relationship between participant's highest level of education and their views on towards the internet as helpful for searching of information about health care services</i> .....      | 136 |
| Table 4-6 <i>Chi-square test of the relationship between participant's highest level of education and their views about their life as a wife</i> .....   | 136 |
| Table 4-7: <i>Chi-square test of the relationship between participants' length of stay in Tasmania towards their views on "How safe they feel"</i> .....   | 137 |

|   |            |
|---|------------|
| <b>Table 4-8: Chi-square test of the relationship between participants’ length of stay in Tasmania towards their views on “personal relationship”.</b>  | <b>137</b> |
| <b>Table 4-9: Chi-square test of the relationship between participants’ area of location from the Philippines towards their views of “Standard of living”.</b>                                | <b>138</b> |
| <b>Table 4-10: Chi-square test of the relationship between participant’s English language proficiency and their views about their standard of living.</b>                                     | <b>138</b> |
| <b>Table 4-11: Chi-square test of the relationship between participant’s English language proficiency and their views on their achievement in life.</b>                                       | <b>139</b> |
| <b>Table 4-12: Chi-square test of the relationship between participant’s English language proficiency and their views towards personal relationship.</b>                                      | <b>139</b> |
| <b>Table 4-13: Chi-square test of the relationship between participant’s English language proficiency towards their views on how safe they feel in a new cultural environment.</b>            | <b>140</b> |
| <b>Table 4-14: Chi-square test of the relationship between participant’s English language proficiency and their views on feeling part of the community.</b>                                   | <b>140</b> |
| <b>Table 4-15: Chi-square test of the relationship between participants English language proficiency and their views and attitudes on how often in a year they visit their family doctor.</b> | <b>141</b> |
| <b>Table 5-1 Axial coding (Tree nodes)</b>  | <b>148</b> |
| <b>Table 5-2 Selective coding (Case nodes) Outline of the hierarchical order of key themes, sub-themes and sub-sub-themes</b>   | <b>150</b> |
| <b>Table 5-3 Social-demographic background of the participants</b>  | <b>151</b> |
| <b>Table 7-1 Health and wellbeing issues found in the literature and from the present study data findings</b>   | <b>200</b> |

# **Chapter 1 – Introduction**

## **1.1. Introduction**

This chapter displays the over-all picture of the study. It begins with a background justifying the research and contextual information which forms the foundation and rationale of this study. It describes the research objectives which spell out clearly the specific problems and issues which the study has identified. This is followed by an overview of the methodology as well as the ethical issues involved. Specifically the chapter puts emphasis on the significance of this research and its limitations. Lastly, the thesis structure is illustrated in terms of composite chapters and contents.

## **1.2. Background and rationale of research**

Intermarriage has paved the way for female migration. Migration is a journey of life and for most intermarried Filipino women migration is like the wheel of fortune, with fortune and misfortune in a new land. Marriage itself is like migration whether people are in the same ethnicity or not. They encounter different challenges not just about culture difference, language barrier, and most importantly discovering their partnership in marriage. Every individual has a unique personality that differ them from another. Therefore, every migrant's experience particularly in reference to intermarriage is a mystery for the participants as well as for the researchers.

The sole purpose of this research is to investigate the health and wellbeing of Filipino wives who came to Australia as a result of intermarriage and now live in the rural parts of Tasmania. Numerous studies have been conducted particularly in the United States of America, Asia and Australia. In most cases Filipino women are a part of the study. However, in the present study Filipino women are not just a part of the study but the only participants of the study. In discussing the background and rationale of this study two important aspects are emphasised: (1) Theoretical background which gives a brief review of intermarriage, the issues and problems

involved and the health and wellbeing of intermarried Filipino women; and (2) contextual background which discusses about Filipino women in Tasmania and the general characteristics of Tasmania particularly its population and health care services.

Before presenting the background of this study, the researcher wants to tell a brief story of how the research came about. The author believes that the necessity of this story needs to be told. As it goes:

*I am a Filipina who is married to an Australian man. My background is a Secondary Social Studies teacher. As a Social Studies teacher in the Philippines I was known among my colleagues and students for being aware of things that happened around the society and in my country in general. However, to come and live with my husband in Tasmania makes me realise that the norms and traditions in Australia are very different and I somewhat feel isolated. My inquisitive mind then starts to play.... What should I do? I wonder if my fellow Filipinos are generally happy here. Are they contented with their life? How are they coping in the new cultural environment? How is their general health and wellbeing? To address all these questions, an opportunity arises, to do something for my fellow 'kababayans' Filipinos. By doing this research I believe I will identify and raise important issues from their collective experience that will assist in providing beneficial information for current and future migrants considering intermarriage. Whatever the issues and experiences of the Filipino women that I may find in my research, I am sure it will bring big contribution to the field of female migration and to the Social Science research.*

This story opens many windows to the complex issues faced by Filipino women in a new country and this is the inspiration for this research.

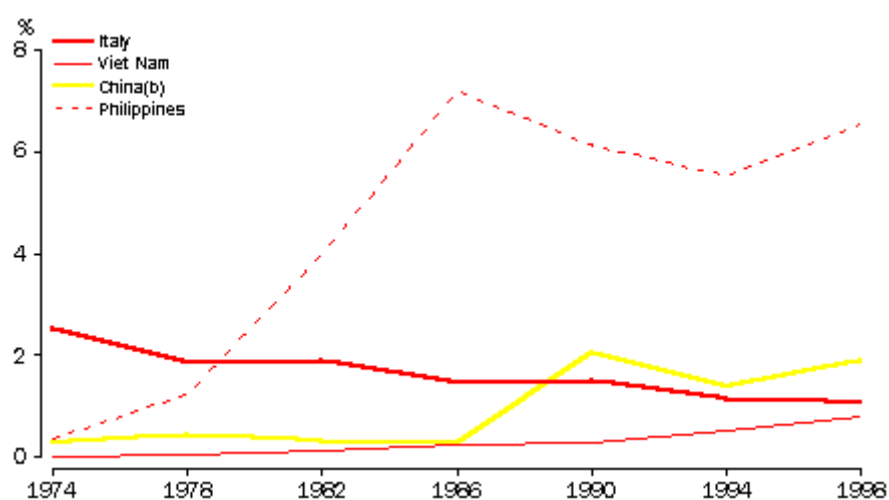
### **1.2.1. Theoretical background**

Intermarriage has been a recognised topic of interest for Social Science research. This has become more important now due to an ever-increasing social trend

creating its own migration patterns. The emergence of social acceptance of all online dating or finding love online is partly responsible for this. In the United States of America there are more than two hundred such websites created which are earning USD 2 million a year. Between 100, and 150,000 women advertise themselves on these websites each year (Angeles & Sunanta, 2007). The rising numbers of interracial marriages have grown at least 500 percent since 1970 (Root, 2001). In absolute number, black-white intermarriages represent the greatest number of relationships, while the largest proportion of intermarriage occurs across various Asian American communities, where the rates can be higher than 50 percent in some cities (Root, 2001). According to Angeles and Sunanta (2007) Thai and Filipino women are among those who supply the on-line bride market. By keying in "Filipina or Filipino women" and "Thai women" in any search engines like Yahoo or Google, more than a hundred thousand results will come up from various website advertisers. In 2007, approximately 15.2 million people of Asian background resided in the United States, which constitutes 5% of the total population. Chinese Americans are the largest Asian group (3.54 million) followed by Filipinos (3.05 million), Asian Indians (2.77 million), Vietnamese (1.64 million), Koreans (1.56 million), and Japanese (1.22 million) (PR Newswire, 2009).

In Australia interracial marriages are increasing, as the population becomes overall more culturally diverse (ABS, 2000). In 1974, 39% of all marriages registered in Australia were mixed marriages (ABS, 2000). By 1998 this amount had increased to more than half of all marriages (52%) (ABS, 2000). People from the UK, Ireland and New Zealand were the largest majority groups of past and present immigrants groups contributing to the overall number of mixed marriages in Australia (ABS, 2000). Furthermore, since Australia's first settlement in 1788, there have been close ties between Australia and the UK and Ireland and later New Zealand, through a common language and from sharing many cultural traditions, beliefs and practices (ABS, 2000). According to Khoo (n.d.) women from Thailand, Japan and the Philippines, have a high intermarriage rates with the Australian-born. However, this is not the case for men from these countries. The high female intermarriage rate is related to migration of women from these countries to Australia to marry Australian

men. This pattern has been observed since the 1970s for women from the Philippines and since 1990 for the other two countries. Furthermore, Intermarriage between Filipino women and Australian men rose very sharply from 1978 and peaked in 1986, (as shown in Figure 1.1) and has remained high, despite a dip in the early 1990s (ABS, 2000). Statistically, marriages involving Filipino women in Australian are four times as high as in Canada and three times as high as in the United States if measured on a per capita basis (Boer, 1988; Clyne & Kipp, 2005). According to the Department of Immigration and Citizenship (2009) the most recent statistics has confirmed the continuous increase in spouse and fiancée visas in recent years with 6,541 prospective marriage visas issued in 2007-2008, and approximately 42,500 grants of partner visas anticipated to be granted in 2008-09.



*Figure 1-1: Overseas born brides marrying long-time Australians*

Source: Unpublished data, Marriage Registrations, 1974-1998 (selected years only) (ABS, 2000)

The theoretical rationale underpinning the study of intermarriage involving intermarried Filipino women is its direct connection to their health and wellbeing. It is significant to note that intermarried Filipino women are migrants. They migrated in rural Tasmania to settle down and lived with their husband's once they have committed. Therefore, it demands adjustment, acculturation and adaptation. Hence, this will be an issue not only to their migration, or to their marriage, but most importantly to their health and wellbeing. Evidence from the analysis in this study indicates that despite intermarried Filipino women being generally happy

with their husbands, several issues have interrupted their assimilation such as: cultural differences, migration issues, social issues, marital issues and barriers to access health care services. Such findings bring new and additional information to the field of female migration, intermarriages and health and wellbeing sector.

According to Jabar (2006) popular topic of intermarriage involving Filipino women tackle about the general aspects of life rather than focusing on specific issue like those conducted by Angeles and Sunanta (2007), Abano (2006), Cahill (1990), Samonte (1986), Mitchell, Bullard and Mudd (1962), and Hunt and Collier (1957). In Australia, most academic articles and journals reported involving Filipino women talk about their consequences of being a Filipino bride. Such studies are those of Cunneen and Stubbs (1996), Hunt and Sta. Ana-Gatbonton (2000), Saroca (2002), and Saroca (2006). To date, very few studies about health and wellbeing issues (as detailed in the research objectives section) have been the main focus of research involving interracial marriages in Australia. Therefore, such research gap insures the need for this study.

### **1.2.2. Contextual background**

The intermarriage of Filipino women and Australian men has become a common social phenomenon in Tasmania. Statistics show that there are more Filipino females than Filipino males in Tasmania. Compared to other Filipino women who come and migrate in other countries like Hong Kong, Singapore, Saudi Arabia, America and Canada for the purposes of being domestic and skilled workers, Filipino women in Australia particularly in Tasmania have come to and migrated to Tasmania as a result of intermarriage. This was confirmed from the research information collected as well as from the data gathered in this study. According to Cooke (1980) Filipinas have been recorded as entering Australia as wives or fiancées of Australian partners since the early 1970s. Other Filipino women immigrant who come and lived in Tasmania was through 'family reunion', where the family sponsored their siblings and other relatives who later on married an Australian man.

Tasmania is the smallest state in Australia, both by area and by population. It is not surprising that the population of intermarried Filipino women is not as big as in the mainland. Tasmanian cities are tiny and congested. The population hit the half million mark at the end of 2008 (Rawlings-Way, Worby, Mocatta, 2008). About 40% of residents live in and around Hobart, about 20% in Launceston, and a further 20% on the north-west coast in centres around Devonport and Burnie (Rawlings-Way, Worby, & Mocatta, 2008). Nevertheless, Filipino women are all over Tasmania. Based on the 2006 Census (2006) there are 770 Filipino women in Tasmania which has an increase of 130 women from the 640 Filipino women population on 2001 census.

According to Rawlings-Way et.al, (2008) Tasmania like other states of Australia has an excellent health care system. It is a combination of privately run medical clinics and hospitals alongside a government-funded system of public hospitals. The Medicare system covers Australia residents for some health care costs. There are excellent, specialised, public health facilities for women and children in Australia's major centres. In Australia's remote location particularly in Tasmania, it is possible there will be a significant delay in emergency services reaching you in the event of serious accident or illness (Rawlings-Way, et al., 2008). Findings of the present study have agreed to Rawlings-Way et.al, however certain issues are prevalent that show a direct influence to the health and wellbeing of intermarried Filipino women as being migrants particularly the weather conditions and culture differences.

Common health risks in Tasmania is the cold weather during winter season which affected Tasmanian people particularly intermarried Filipino women who come from a tropical country. Hypothermia is a significant risk, especially during winter months especially in Tasmania. Strong winds produce a high chill factor that can result in hypothermia even in moderate temperatures (Rawlings-Way, et al., 2008). Early signs include the inability to perform fine movements (such as doing up buttons) shivering and a bad case of 'umbles' (fumbles, mumbles, grumbles and stumbles). The key elements of treatment include moving out of cold, changing out of any wet clothing into dry clothes with wind and water proof layers. Adding insulation and providing fuel (water and carbohydrate) to allow shivering, this builds



the internal temperature (Rawlings-Way, et al., 2008). Intermarried Filipino women participants that were interviewed have emphasised the effects of the cold weather to their overall health conditions and this was confirmed by the survey results. Because of Tasmania's small land area, it enjoys a maritime climate, which means that it is rarely extremely hot or extremely cold. Many Australians find it much colder than anywhere in the mainland and storms can deposit wintry conditions anytime of the year, including at the height of summer. Tasmania has four distinct seasons: summer, winter, spring and autumn. Tasmania is in the path of the roaring 40's, a notorious current of wind that encircles the globe and produces very changeable weather. Hence, it is not surprising that the west and southwest can be blasted by strong winds and drenched by heavy rain (Rawlings-Way, et al., 2008).

According to Australian Bureau of Statistics (ABS) (2010), majority of the Tasmanian population (79.1%) aged 15 years and over ate 4 serves or less of vegetables per day. At the same time, 79.6% of the Tasmanian population aged 18–64 years and 75.3% aged 65 years and over consumed 4 serves or less of vegetables per day. Over half (54.1%) of people aged 18–64 years reported that they did not eat fruit or ate 1 or less serve of fruit per day, while 40.9% of those aged 65 years and over indicated this to be the case. This health risk behaviour of Tasmanians shows similar results to the present study in which intermarried Filipino women also have issues in terms of vegetables and fruits intake due to the absence of the familiar vegetables and fruits from their native country. It also implies the significance of the present findings which reports that it is only natural for the intermarried Filipino women to undergo so-called health related issues while they are acculturating themselves to the new cultural environment as well as adapting to the available foods and goods.

However, mental health and behavioural problems are another health related issues of Tasmanians. Over two-thirds (257,000 persons aged 18 years and over, or 70.3%) of Tasmanians experienced low levels of psychological distress, while 68,200 or 18.7% of the Tasmanian population aged 18 years and over reported moderate levels of distress (ABS, 2010). About 11.0% (40,300 persons) reported high/very high levels of psychological distress, levels that possibly indicate a need for

professional help. Of those reporting high/very high levels of distress, people aged 45-64 years accounted for 44.4%, followed by those aged 25-44 years (24.3%) (ABS, 2010). In relation to the intermarried Filipino women participants, data findings reported that mental stress or psychological stress is not common for them when they were in the Philippines. It is only here in Tasmania that they fully understood and encountered such stress like emotional stress, mental stress and physical stress which causes from the absence of familiar faces, family, new environment, new culture, new practices etc.

Even during early years 1950's and mid 1970's the main health for migrants that attracts attention to the medical practitioners are mental illness and stress, the social context of medical care, physical illness, hospitalisation and alcoholism (Palmer & Short, 2000). Martin noted as pointed out by Palmer and Short (2000) that these problems were usually defined problems within immigrants, not problems within health care system. Palmer and Short (2000) further explain, "medical research revealed that immigrants were vulnerable to mental health problems because of pre-migration experiences of deprivation and stress, and because of ignorance and fear, low standards of literacy and alien cultural values and expectations" (p. 270). Therefore, many immigrants' encountered difficulties and experienced frustration and dissatisfaction when accessing mainstream health services and result to under-utilisation of health services (Palmer & Short, 2000).

According to Palmer and Short (2000) Australia's immigrant population is diverse in terms of place of birth, culture and socio-economic status in the country of origin. Therefore, the health of diverse immigrant groups and their degree of social disadvantage vary according to a range of interrelated social factors including: how recently they arrived in Australia; proficiency in spoken and written English; cultural difference between native and host culture; socio-economic status in country of origin; per capita income of country of origin; possession of trade/professional skills and recognition of these in Australia; and the supportiveness of family or ethnic social networks.

### **1.3. Research objectives**

This study has the following research objectives:

**Research objective 1:** To examine the acculturation of intermarried Filipino women in rural and regional Tasmania. The focus will be on the following aspects:

- Identity and new role;
- Interpersonal relationship issues;
- Language and communication problems; and
- Cultural shocks and coping strategies.

**Research objective 2:** To examine the views of intermarried Filipino women about their health concept and health care in rural and regional Tasmania. The focus will be on the following aspects:

- Their well-being in a new cultural environment;
- Their traditional views on health and health care; and
- Their expectations of health services in Australia in general and in rural/regional Tasmania in particular.

**Research objective 3:** To identify problems facing intermarried Filipino women in accessing health care in rural and regional Tasmania. The focus will be on the following aspects:

- Their awareness of health care services in rural and regional Tasmania; and
- Issues relating to their access to health care services in rural and regional Tasmania: e.g., risk, vulnerability, and marginalisation.

**Research objective 4:** To examine social and cultural capitals which enhance the well-being of intermarried Filipino women in rural and regional Tasmania. The focus will be on the following aspects:

- Interpersonal relationship: family, friend network, neighbourhood;
- Filipino community in Australia and in Tasmania;
- State and local communities; and
- The media and the Internet.

## **1.4. Overview of the methodology**

Deciding the method to use in an academic research includes certain aspects such as topic of research, the sample, existing literature, and the capabilities of the researcher. Hence, this research examines the health and wellbeing of the intermarried Filipino women in rural Tasmania, and mixed methods research design was employed. It is a combination of quantitative and qualitative methods. Quantitative method was used to gather precise statistical information through survey questionnaires while qualitative method was applied to enrich the data gathered from the survey via semi-structured interviews. The specific mixed methods design used in this study is the concurrent triangulation mixed method design. Therefore data was gathered concurrently.

A total of 250 intermarried Filipino women were recruited to participate in this research via third parties and snowball sampling process. Only 145 responded willingly to the invitation. Among 145 participants, 15 of them consented to participate in semi-structured interviews. The recruitment was done through Migrant Filipino Community Associations and via snowball process. Ethics application was sought prior to any data collection

The importance of using quantitative method is for the researcher to get mass responses for reporting purposes. The results were based on the validity and reliability of the measurement. As the data analysis process goes through the statistical software (SPSS 16) wherein, data are analysed descriptively and inferential statistic were also applied to determine the significance of the results. However, a pilot study was conducted before the full implementation of the survey questionnaire. Questionnaires were piloted for ensuring its validity and reliability.

Content validity was assessed through discussions with supervisors and external experts. The reliability of the questionnaire was conducted by Cronbach's alpha coefficient test on the scaled question items, while qualitative data were analysed through grounded theory analysis and thematic analysis with the aid of NVivo 8 software. To make sure of the integrity of the collected qualitative data, the encoding process was done using the actual words (raw data) and was coded and recoded. Member checking approach is another technique applied to validate the data in which summaries and findings were carefully checked by primary and co-supervisors.

The reasons behind using mixed method of quantitative and qualitative are: the research problem demands statistic results and rich data, therefore using one method alone will not prove or even confirm what the research needed to provide; and some research only used one of the methods (i.e., quantitative or qualitative) which entails the importance of using the two methods in this research as the strength and weaknesses of the two methods complement each other.

Data finding from both methods quantitative and qualitative do complement each other as well as possibly contradict each other. That is the principle of using mixed methods the researcher is not only challenged by its findings but also how to present the findings. Therefore, the process of presenting the data analysis results of mixed methods is to combine and integrate to assure that the results is been correctly presented. Specifically, quantitative data analysis presented the statistical information in terms of participants' profiles, their responses about their views and attitude relating to the questions raised in the questionnaire, their access to health care services, their personal wellbeing and their general health and wellbeing. The way the questionnaire is constructed in the survey already instigates new findings that will be an addition to the existing body of knowledge in research. Several factors were also identified that have significant effects to the health and wellbeing such as: age, highest level of education, proficiency in English language and length of stay in Tasmania.

However, qualitative data findings do not only show and identify issues on health and wellbeing but also describe the coping behaviours employed by the intermarried Filipino women to manage their day-to-day living and the problems that may arise. The coping behaviours found in the analysis fill in the gaps of the existing literature.

## **1.5. Ethical issues**

Having human participants involved in the study potentially raises ethical issues. The interview questions consist of slightly personal questions about the intermarried Filipino women's experiences regarding their views, concept and beliefs on health and wellbeing, and their access to health care services as well as their role as a wife within the family. The researcher is a Filipino woman herself and her familiarity with the Filipino culture and society could be useful in helping her to interact comfortably with the participants in the interviews. They were assured of full confidentiality and anonymity for all the information they have provided. Before the interview, the researcher read the consent form to the participants which they signed prior to the interview to make sure that they fully understood what they were undertaking. Hence, a minimal risk ethical permit was applied for this research. The research questions were also not too deeply personal to avoid some ethical issues for both parties.

## **1.6. Significance of the study**

This research is important for the researcher for the following reasons: this study deals with the Filipino women and it investigates about their health and wellbeing; the information gathered from the existing literature as well as from the data will more likely help the intermarried Filipino women themselves as well as to female migrants who are engaged in interracial marriage and who are also living in the rural areas of Tasmania.

### **1.6.1. Theoretical significance**

Due to the rapid increase of intermarriages around the globe, it draws attention to the health policy makers, educational institutions and scholars from various disciplines. It is evident to several article reports that are in different scholarly journals, academic research and books. To fill in the gaps of the existing literature (with the Filipino women particularly in Australia) the present study focused on the most dominant scholarly journal article theme issues which are classified into two categories: interracial marriages (concerning negative themes) and health and wellbeing issues. In terms of intermarriages several negative issues were identified such as: mail-order-brides, trafficking, exploitation, domestic violence, racism, sexism, spousal homicide and discrimination. However, in terms of health and wellbeing issues the following themes were found: mental health, strength of social network and marital issues (i.e., marital breakdown and financial problems), immigration issues, depression, cultural factors, and access to health care services. The reasons behind in identifying and enumerating the different issues found in the literature are to ensure that the present study made some contribution to this complex social issue. This will be explained in the data analysis chapters (4 and 5) as well as in the discussion chapter that the findings of the present study do not only support the existing research but also provide a new insight that highlights significant current social developments in this area.

This research was designed not only to examine the health and wellbeing of intermarried Filipino women and their access to health care services but also to present intermarried Filipino of rural Tasmania in the area of female migration. Numerous research studies have been undertaken regarding Filipino women around the globe. In Australia, most of the research was conducted in Sydney, Queensland, Melbourne, Canberra and Perth. There are only a few academic research topics that involve Filipino women in Tasmania in general. Most of this research on the Filipino women is just sketchy, and not clone with the main population sample. Hoang's (2008) research opened a new window on research dealing with migrant women in Tasmania. The only scholarly journal that studies focuses on Filipino women in Tasmania was Clark (2004) where she investigated the experiences of Filipino

women who have migrated from the Philippines to Tasmania and who were commonly referred as a “mail-order-bride”.

Other research about the intermarried Filipino women and to all the female migration mainly focuses on negative themes like, exploitation, trafficking, abuse, violence and their reason for marriage. This research does not only examine the factors that affect health and wellbeing but also it analyses the mental and emotional aspects of the intermarried Filipino women as how they handle possible culture shock and all the experiences they have been going through in interracial marriage.

In general this research makes contribution to intercultural studies, migrant health care, globalisation, intercultural communication, and rural studies.

#### **1.6.2. Discourse significance**

Current interest in the issues of wellbeing spans a wide range of policy arenas, from local government, health, and education to the work of the devolved administrations and this reflects the recent growth in academic work in this area. However, the wellbeing research has yet to produce many specific policy recommendations (McAllister, 2005). Thus this research is expected to give more insight into the health providers including community health workers about the expectations and the likely behaviours of Filipino women. In return, hopefully the intermarried Filipino women as well as other intermarried female migrants will be properly assessed physically and mentally.

Adding to findings of numerous studies about health issues of migrants and the consequences of being a Filipino bride, this research is expected to contribute to the understanding of interracial marriage in Australia. This research will venture into the minds of the intermarried women in how significant their lives are in the new ‘called home’; that their health and well-being is as important as the country’s economy. Since “people are the real wealth of nations”, (Lloyd, Newell, & Dietrich, 2004) for the intermarried Filipino women “health is their wealth”. Thus, their



experiences in accessing the health care services will give them a better understanding as how important it is to their health and well-being.

The findings of this study add to the understanding of the need of research dealing with similar themes because it provides common and specific information about the likely behaviour of a migrant engaged in interracial marriage such as their access to health care services; the way they look after themselves and the way they adopt the new cultural environment.

### **1.7. Limitation of research**

According to the 2006 census (2006), there were 770 Filipino female in Tasmania. Invitations were sent to 250 of these women to participate in the survey of which 145 participated. The number of participants posed a limitation to the study. As discussed in the literature review Filipino women by nature are shy and very private. The longer a Filipino woman lives in a rural area, the more reserved she is. Since this study is about Filipino women in rural Tasmania, there is a good reason why these Filipina were not responding. Another reason as to why the target sample size was not achieved is because the researcher herself does not have a personal contact with the invited participants. As mentioned earlier, the participants were recruited via Filipino community agencies. Once the questionnaires were distributed by the agencies, it is then beyond the researcher's control. However, the researcher did not fail to reinforce responses by sending a reminder letter and making follow-up phone calls.

Despite this limitation, the researcher believes that the study provides reliable and valid results from the data gathered from the questionnaires and semi-structured interviews. The sample size is 58 per cent of the total population and it is more than enough to prove reasonable results.

## 1.8. Structure of the thesis

Having described the background and rationale, aims and objectives of this research as well as the significance in this chapter, the following outline provides an overview of other chapters.

**Chapter 2 – Literature review:** critically reviews literature relevant to interracial marriages involving Filipino women and other Asian migrants. It discusses the different issues encountered through interracial marriage, particularly intermarried Filipino women and how this affects their health and wellbeing.

**Chapter 3 – Methodology chapter:** explains the methodology applied in detail. It discusses the research methods, research approach, data collection and data analysis. Reliability and validity issues are also highlighted in this chapter. It explains how reliable and valid the research instrument is in meeting the requirements and extracting new information. An ethical issue of research is also discussing in this chapter.

**Chapter 4 – Quantitative data analysis:** reports on the findings resulting from the questionnaire data analysis. It contains statistical information to how socio-demographic backgrounds of intermarried Filipino women living and working in rural Tasmania (e.g., age, level of education, and length of stay in Australia, employment status, and English language proficiency) affect their views and attitudes on health and wellbeing in terms of health concept, access to Healthcare services and acculturation strategies.

**Chapter 5 – Qualitative data analysis:** presents the results obtained from the interview data analysis. It elaborates the causes and effects of health and wellbeing issues facing intermarried Filipino women as well as to the barriers on their access to health care services. It also confirms the information initially obtained from the questionnaire.

**Chapter 6 – Discussion and interpretation:** presents the integration of the results from both analyses (quantitative and qualitative). As mentioned, this research employs mixed method a combination of quantitative and qualitative therefore this

chapter outlays the significant findings by interpreting and combining of the data analysis results.

**Chapter 7 – Conclusion:** states the final remarks such as the significance of the study and the researcher's reflection in doing the research.

## **1.9. Conclusion**

This chapter has presented an overview of the thesis. It covers the research aim and objectives, the rationale and the scope of the research. This research investigated the health and wellbeing issues of the intermarried Filipino women in rural Tasmania and their access to health care services. Detailed background information of the intermarried Filipino women has been provided. The significance of the study has been reported. The limitations of the study have been recognised. The next chapter will explore the review of the literature.

# **Chapter 2 – Literature Review**

## **2.1. Introduction**

Interracial marriage has become a common social phenomenon and has started to attract some attention in research. This chapter presents a review of the previous and most recent literature covering interracial marriage involving Filipino women and other Asian migrants. The review is divided into three sections based on the key themes identified in the literature: the first theme is Filipino women in interracial marriages in a global context with specific reference to demographic statistics. The second theme is intermarried Filipino women's health issues whereby their views and concept about health and health care, their access to health care services and other health problems are critically examined. The third theme is intermarried Filipino women's wellbeing. The discussion also covers other migrants' health and wellbeing as there are some common experiences shared among migrant women. The sources of this literature review are taken from different scholarly journal articles, dissertations, conference proceedings, empirical studies, government reports, historical records and other databases and educational websites.

## **2.2. Filipino women in interracial marriage**

Filipino women are virtually all over the world. They have migrated to other countries for different reasons: being skilled workers, students, tourists and spouses of foreign nationals. Regions and countries with the most number of intermarried Filipino women are Asia, United States, Europe and Australia. In order to have a full grasp of interracial marriages, it is best to define the term first. Interracial marriage is a term used to describe a marriage that takes place between two people who are from different racial or ethnic groups (Yancey & Lewis, 2009). Interracial marriage can include the union of Asians, Hispanics, Blacks, white Americans, black Americans, Indians, Chinese, Koreans, Mexicans, Malaysians and Hindus (Alouise, 1998; Knox & Schacht, 2010).

Interracial marriage in the Philippines started in its early history when the Malays, Chinese, Spaniards, Negritos and Americans inhabited the country. In fact Filipinos have become a unique blend of all these people. Negritos were the first inhabitants in the country followed by the Malays, who spread throughout the archipelago through intermarriage (Dolan, 1991).

According to Cooke (1980) intermarriage between Filipino women and foreign men has taken place for a long time. It was formed through the context of traditional and colonial ties. It was commonly involved The American, Spanish nationals and other members of Chinese groups who came in the Philippines during colonial times. This practice continue till at present and for the last decade intermarriage involving Filipino women are not only with the Americans but also to the European nationals as well as Japanese, and men from New Zealand and Australia. However, the practice of Filipino men marrying foreign women is not common. According to the National Statistics Office (NSO) (2007), the most number of foreign brides married to Filipino men are Japanese women (n=81) followed by Chinese, Indonesian, and Thai in equal number (n=7) and intermarriages between Filipino men and American women have the smallest number (n=5).

Interracial marriage has been a growing social phenomenon in the world and Filipino women and Thai women are widely mentioned. There are different contexts of interracial marriage. In one context, it can be seen as a very rare phenomenon whereas in another context, it is seen as a common phenomenon. According to Le (2007), the three main contexts of intermarriage on the basis of ethnicity and nationality are:

#### **Context 1: intermarriage of the same nationality but different racial backgrounds**

In a multiracial society such as the U.S., Australia and Canada which are “young” nations, intermarriage of people of different racial backgrounds is a common phenomenon. In Australia due to the fact that many Australians were born overseas, interracial marriage between white Australians and Asian-background population has been a contributing factor to the cultural and racial melting pot of Australia.

## **Context 2: intermarriage of different ethnicity and nationality**

For the past two decades, Australia has witnessed a phenomenon of intermarriage of different ethnicity and nationality. It is normally the case that white Australian men marry Asian women but not the other way round. Intermarriage between Australian men and Filipino women is more widespread than that between Australian men and women of other Asian countries. Australia had among the highest incidence of interethnic marriages in the world (ABS, 2000). Between 1996 and 1998, 52% of marriages in Australia were “mixed” in the sense that they involved people from different countries of origin (whether overseas-born or second generation) whereas 37% of all marriages are between people of English speaking background (long-time Australians, migrants from the UK, Ireland or New Zealand) and non-English speaking background. While there was variation between different groups (for example Filipino women were more likely to stay in a marriage relationship for a longer time with Australian men), interethnic marriage had increased markedly – 33% – over the past 25 years (ABS, 2000).

## **Context 3: intermarriage of the same ethnicity but different countries**

Parents tend to hold the traditional view that they prefer their children marrying people of the same ethnicity. This view is popular in big cities where there are strong ethnic communities such as Cabramatta and Bankstown in Sydney and Footscray in Melbourne (Le, 2007). There are also many cases of Vietnamese and Indian Australians going back to their original home countries to marry spouses of the same ethnicity and sponsoring them to migrate to Australia.

Among the three contexts, context two is common around the globe. There is a large population of interracial marriage particularly in the United States, Australia, Asia and Europe. According to Sanchez and Gaw (2007), Filipino Americans constitute the second-fastest-growing Asian-American group following Chinese Americans. Nearly 2.9 million Filipinos live in the United States. The highest concentrations are in California, Hawaii, and the East Coast. Sanchez and Gaw (2007), also emphasised that:

*The U.S. Census Bureau predicts the Filipino American population to be over four million by 2030. Foreign-born Filipino Americans outnumber American-born Filipinos by two to one. They have the highest rate of interracial marriages among Asian minorities, which influences acculturation, ethnic identification, and self-perception. (p. 810)*

In Asia, Japan has a large number of marriages between Japanese nationals and Filipino women. In the year 2006 alone, there were 5,468 marriages (National Statistics Office, 2006). Other foreign nationals who married Filipino brides are the Americans (n=3,002), Australians (n=569), Chinese (n=393), Germans (n=205), Spanish (n=124) and 3,519 Filipinos were married to other foreign nationals (National Statistics Office, 2006).

However, in Australia, Filipinos form the third largest non-European immigrant communities (behind Vietnamese and Chinese immigrants). A significant number of Filipinos immigrated to Australia between the 1960s and the 1990s and Filipinos (men and women) remain one of the fastest growing immigrant communities in Australia (Department of Foreign Affairs, 2006). In 1989, more than 700,000 Filipino women became a wife and fiancées to Australians, Germans, and Taiwanese and British nationals (Reyes, 2007). A total of 20,000 Filipino women are married to Australian men, some 90% of whom came through the system of serial sponsorship (Reyes, 2007). In 1995-96, hundreds of Filipino women were married in a mass ceremony to members of a religious organisation called the "Moonies", in which the majority was South Korean men (Reyes, 2007). In 2001, there were 103,990 Filipino migrants reported, of whom 65.5% were women. More than 70% of these women were sponsored as fiancées or spouses of male Australian residents (Latrobe University, 2006). The embassy receives some 1,500 visa applications year round, of which 400 are for fiancée visas (Abano, 2006). The According to Latrobe University (2006), most Filipinos (90%) enter and coming to Australia as "family reunion" category immigrants. The rate of Australian citizenship for the Philippines-born in Australia was 93.5%, compared to all overseas born of 75.1%.

There are a large number of Filipino migrants in Australia and Table 2.1 (below) shows their distribution by state and territory. The majority of Filipino migrants live in New South Wales (50.2%) followed by Victoria (21.6%) and the lowest number goes to Tasmania (0.7%) since in terms of population it is the smallest state in Australia (Latrobe University, 2006).

**Table 2-1:** *Distribution of Filipino Migrants in Australia by State/Territory*

| State                        | Population     | Percentage  |
|------------------------------|----------------|-------------|
| New South Wales              | 52,240         | 50.2%       |
| Victoria                     | 22,500         | 21.6%       |
| Queensland                   | 15,450         | 14.9%       |
| Western Australia            | 5,400          | 5.2%        |
| South Australia              | 4,510          | 4.3%        |
| Northern Territory           | 1,730          | 1.7%        |
| Australian Capital Territory | 1,390          | 1.3%        |
| Tasmania                     | 760            | 0.7%        |
| <b>Total</b>                 | <b>103,980</b> | <b>100%</b> |

Source: Adapted from Latrobe University (2006)

According to Sarocca (2002) the majority of marriages between Filipino women and Australian men in Australia started from initial introductions through networks of families and friends, followed by letter writing, telephone calls, and emails and so on. However, most Filipino-Australian couples nowadays do not meet through introduction agencies. The informal networks established by Filipino women who had previously migrated to Australia provide a major channel by which Australian men meet female partners from the Philippines. These networks allow the personal introduction of Australian men to female family members and friends in the Philippines. Moreover, at present, due to advancement of technology, personal introduction of Australian men to female family members and friends in the Philippines can also be done on the internet, as there are video call, voice call, chat room, etc. which are available through different internet sites such as Yahoo Messenger, Skype, Facebook, Friendster. These internet sites make introduction of female family members quicker and easier.

Since the focus of this study is in rural Tasmania, it is important to include the intermarried Filipino women in Tasmania. Like other Filipino women, the



intermarried Filipino women in rural Tasmania came and migrated to Tasmania by fiancée and spouse visas. Some of them came to Tasmania through sponsorship from their family members who were already here, then went through the process of meeting Australian men and then getting married here. The intermarried Filipino women are all over Tasmania and it is evident by the number of Filipino organisations around the state: Hobart (Filipino Women Support Group, and Philippines-Australia Community of Tasmania Inc.); Northern Tasmania (Philippine Australian Club and Philippine-Australian Friendship Association of Launceston Inc., and Filipino-Australian Performing Group of Launceston); Northwest Tasmania (Bayanihan Club Filipino Australian Association of Tasmania) (Multicultural Council Tasmania Inc., n.d.). The above organisations were created by the Filipino people themselves to help support each other and especially to offer support to the new comers. The Filipino community in Tasmania attempts to help Filipino women settle in Tasmania, offering them the comfort in knowing that they have the support of their country fellows and the feeling of belonging to a close and caring community. Every year the Filipino people in Tasmania commemorate the Philippine Independence Day where they showcase most of their culture such as native folk dance and most Filipinos who attend the celebration wear the popular “Barong Tagalog” for men and the “Maria Clara dress” or Filipiniana dress for women. It is also a time when the Filipino people are able to see and eat different Filipino dishes and delicacies.

As listed in Table 2-2, there are many Filipino migrants in other Australian states. Therefore, there are more organisations that these migrants created. Not many research studies mention the different Filipino organisations and there has not been a single study that listed all the organisations. Hence, this is one of the gaps that this literature review has identified and this information will be useful for intermarried Filipino women to find and get to know their fellows. The importance of this list of organisations to intermarried Filipino women as well as all Filipino migrants is that this will make them feel welcome and secure, knowing that they have many fellowmen around the country. Seeing someone from their own native land and being able to mingle with them makes their stay in Australia happier. In other

words, this helps boost their sense of wellbeing through the courage and inspiration they get from fellow Filipinos.

Table 2-2- *Filipino Community Organisations in Australia by State adapted from FILOPAGES (2008)*

|  |  |
|--|--|
| <b>New South Wales/Australian Capital Territory:</b> |  |
| 1.   | Australian Devotees of our Lady of Penafrancia, Inc.             |
| 2.   | Club of ANU Filipino Student                                     |
| 3.   | El Shaddai Prayer Partners International Chapter                 |
| 4.   | Filipino Australian Society of the Hunter Valley Inc.            |
| 5.   | Filipino Community of the Hunter Region Inc.                     |
| 6.   | FILCOM Sports Club   |
| 7.   | Filipino Support Group   |
| 8.   | Leon Aguila Association  |
| 9.   | Philippine Australian Community Foundation                       |
| 10.  | Philippine Australian Community Services Inc.                    |
| 11.  | Philippine Australian Sports & Culture Inc.                      |
| 12.  | St. Scholastica's College Alumni                                 |
| 13.  | The Cabanela Memorial Boxing Brotherhood, Australia              |
| 14.  | Rondanihan Inc.  |
| <b>Victoria:</b>                                     |  |
| 1.   | Australian Asian Golf Club                                       |
| 2.   | Filipino Community Council of Vic. Inc. (FCCVI)                  |
| 3.   | Bataan Foundation  |
| 4.   | Filipino Community Welfare Services                              |
| 5.   | Cordillera Dance Group   |
| 6.   | Filipino Elderly Australian Association                          |
| 7.   | Dulaang Bayan Melbourne  |
| 8.   | Gabriela Australia   |
| 9.   | Filipino Artists of Melbourne                                    |
| 10.  | Ilocano Assoc.   |
| 11.  | Filipino Australian Business Association Inc.                    |
| 12.  | Ilonggo Assoc.   |
| 13.  | Filipino Australian Friendly Association                         |
| 14.  | Filipino Australian Friendship Association                       |
| 15.  | Migrante Melbourne   |
| 16.  | Filipino Australian Senior Citizens Advisory Council of Victoria |
| 17.  | Pampagueno Club  |
| 18.  | Filipino Australian Society of Northwest Inc.                    |
| 29.  | Phil. Cultural Society for Elders Inc.                           |
| 20.  | Filipino Australian Sport Assoc. Of Victoria                     |
| 21.  | Migrante Melbourne   |
| 22.  | Filipino Broadcasting Group                                      |
| 23.  | Pampagueno Club  |
| 24.  | Filipino Community Council of Vic.                               |
| 25.  | Phil. Cultural Society for Elders Inc.                           |

|                           |  |
|---------------------------|--|
| <b>Queensland:</b>        |  |
| 1.                        | Catholic Filipino Australian Chaplaincy  |
| 2.                        | Filino Australian Foundation of Qld.   |
| 3.                        | Filipino Community Coordinating Council of Qld.  |
| <b>Queensland:</b>        |  |
| 4.                        | Filipino Australian Affiliation of North Qld   |
| 5.                        | Filipino Australian Community Gold Coast Inc.  |
| <b>Western Australia:</b> |  |
| 1.                        | South West Filipino-Australian Association Inc.  |
| 2.                        | FACPI Club House   |
| <b>South Australia:</b>   |  |
| 1.                        | Filipiniana Community Newspaper  |
| 2.                        | Filipino Settlement Co-ordinating Council of South Australia Inc.                              |
| <b>Tasmania:</b>          |  |
| 1.                        | Filipino-Australian Performing Group of Launceston   |
| 3.                        | Filipino Women's Support Group, Inc.   |
| 2.                        | LuzViMinda, Filipino Communities Council of Tasmania Inc.                                      |
| 4.                        | Philippine Australian Club and Philippine-Australian Friendship Association of Launceston Inc. |
| 5.                        | Bayanihan Club Filipino Australian Association of Tasmania                                     |

As the number of intermarried Filipinos living in rural Tasmania or Australia in general increases, more health issues involving them have arisen. The section below will discuss the different health issues involving intermarried Filipino women.

### **2.3. Intermarried Filipino women's health issues**

Health issues differ in accordance with people's lifestyle and culture. It also differs according to the views, beliefs and attitude of the migrants/immigrants who seek to live a comfortable life in their host country. This section will tackle intermarried Filipino women's views, beliefs and concepts about their health, access to health care services and different health issues found in the literature. Numerous research projects have been conducted on health issues of the population and on migrants; however, not many have focused on health issues of intermarried Filipino women.

### 2.3.1. Concept, views attitude about health

Every individual has his or her own idea of being healthy and each culture has its own views and concept of what being healthy means. Health is viewed differently through cultural lenses. As Spector (2000) says, some see it as the freedom from and absence of evil. Illness, to some, is seen as punishment for being bad or having committed evil acts. This concept is common in traditional Filipino beliefs that, in most instances, if a person does something cruel to his fellowmen, then after a few weeks he will get sick. Coward (1993) argues that “the conception of disease has changed: disease is no longer seen as either the curse of mankind or as a completely arbitrary phenomenon. Instead disease and wellbeing are both seen as having direct personal meanings” (pp. 94-95).

Nightingale (1859) discovered that health and illness are connected with the environment. She believes that a person’s health is considerably affected by ventilation, noise, light, cleanliness, diet and a restful bed. This concept of health best describes the Australian people since the environmental factors of health are indicators of their health. Australians are perceived as health conscious. However, Italian’s view of health is likely related with the Filipino (as explained above) as Legge (1981) points out:

*Italian deep inside do not regard illness as a fact of life but as a real piece of bad luck, being direct descendants from Latin people they were very superstitious. They believed that since they were born they have to die as well. They also believed that they should die in the natural painless death of old age. They think that sick person is a most unlucky one, which he or she is a victim of cruel fate, and for this reason he or she expects sympathy, understanding, affection and care from relatives, friends and doctors. (p. 25)*

Health is so important that money, career, reputation and education are of no value unless combined with good health (Legge, 1981). Legge (1981) also cites an Italian proverb that says: “a live donkey is better than a dead doctor” (p. 25). He further explains that to be fit is something that we expect, just as we assume that the sun

will rise every morning. It is something that we have the right to, as much as we have the right to eat, to work and to enjoy.

Eckersley (2007) complements Legge's (1981) concept of health arguing that:

*Human health has multiple sources: material, social, cultural and spiritual. We are physical beings with material needs for nutritious food, clean air and water, and adequate shelter, as well as physical activity and sleep. We are also social beings who need families, friends and communities to flourish. We are cultural beings — of all species, we alone require cultures to make life worth living. And we are spiritual beings, psychically connected to our world.*  
(para. 1)

Health, therefore, is the ultimate source of human life based on Eckersley's description of health. However, human health, particularly migrant's health, is continuously challenged by conflicting views, concept and beliefs about how to look after one's health. For Filipino women, health is based on the principle of balance. According to this principle, health is believed to be a result of balance, while illness is due to humoral pathology and stress is usually a result of some imbalance. This balance relates to temperature in food, climate, and body elements and diet, and it influences people's and migrants' daily activities of living and promotion. To attain good health and avoid illness, migrants must adjust to the environment in a holistic manner (Inouye, 1999). Illustrated below are a range of humoral balances that influence Filipino health perceptions: rapid shifts from "hot" to "cold" lead to illness "warm" environment is essential for maintaining optimal health; cold drinks or cooling food should be avoided in the morning; an overheated body is vulnerable to disease; a heated body can get "shocked"; cooling quickly can cause illness; a layer of fat maintains warmth and protects the body's vital energy; imbalance from worry and overwork creates stress and illness; emotional restraint is a key element in restoring balance; a sense of balance imparts increased body awareness (Becker, 2003).

According to Anderson (1983) and Rosaldo (1980), researchers who are studying in different parts of the Philippines have recorded a range of cultural practices around

health. However, the dominant unifying theme is that of “balance”. Most studies involving migrants in relation to this concept were conducted in the United States and focused mainly on specific illnesses. Becker (2003) examined Filipino Americans’ cultural traditions surrounding bodily awareness, particularly how the principle of balance informs their views and the link to self-management of chronic illness. In his study, Becker found out that balance is central to Filipino Americans’ awareness of bodily signs and symptoms related to chronic illness, as well as to actions they take to manage their chronic illness. However, in terms of cancer, Wu and Bancroft’s (2006) research findings show that avoidance is a main theme for Filipino American women when dealing with cancer diagnoses. Factors facilitating Filipino American women to undergo screening are support from family members, recommendations from familiar physicians, health insurance reinforcement, and personal attributes such as physical symptoms, family history, past diagnosis and health literacy.

In Kagawa-Singer and Maxwell’s (1999) study, they reported that Filipino Americans harboured many different views and misconceptions, including beliefs that breast cancer can be caused by stress (64%), air pollution (48%), doing something morally bad (57%), and hitting or bumping the breast (79%); only five women believed breast cancer to be contagious. However, they emphasised that these misconceptions did not affect utilisation. This is because of the Filipinos’ strong faith in God. The strong Roman Catholic influence causes many Filipinos to regard illness and suffering as unavoidable in certain circumstances (“it is in God’s hand”) which results in a fatalistic attitude towards prevention. Kagawa-Singer and Maxwell’s (1999) data appears to support these notions in which 31% of Filipino-American women in their sample expressed the belief that breast cancer is usually caused by things beyond human control, such as spiritual forces, fate or predestination. Therefore they felt they had little control over the disease.

Filipino health beliefs and practices are oriented towards protection of the body (treatment concept) such as: *flushing* – the body is thought to be a vessel or container that collects impurities which are eliminated through physiological processes such as sweating, vomiting, expelling gas or having an appropriate

volume of menstrual bleeding; *heating* – adapting the concept of balance between “hot” and “cold” to prevent occurrence of illnesses and disorders; and *protection* – safeguarding the body from outside influences such as supernatural and natural forces (Periyakoil & Dela Cruz, 2010).

In response to illness, according to Periyakoil and Dela Cruz (2010), older Filipino migrants tend to deal with illness with the help of family and friends, and by faith in God. Complete cure or even the slightest improvement in a malady or illness is viewed as a miracle. Before seeking professional help, older adults tend to manage their illnesses by self-monitoring the symptoms, ascertaining possible causes, determining the severity and threat to functional capacity, and considering the financial and emotional burden to the family. They may even resort to utilising traditional home remedies such as alternative or complementary treatment. They may discuss their concerns with a trusted family member, friend, spiritual counselor or healer (Yeo et al., 1998). Seeking medical advice from family members or friends who are health professionals is also a common practice among Filipino older adults and their family members, especially if severe somatic symptoms arise (Anderson, 1983; Periyakoil & Dela Cruz, 2010).

In addition to seeking family help and home remedies, Filipino women migrants also have other ways of coping such as: *Tiyaga* – patience and endurance, the ability to tolerate uncertain situations; *Lakas ng Loob* – flexibility, being respectful and honest with oneself; *Tatawanan ang problema* – humour, the capacity to laugh at oneself in times of adversity; *Bahala Na* – fatalistic resignation, the view that illness and suffering are the unavoidable and predestined will of God, which the patient, family members and even the physician should not interfere; *Pakikisama* – conceding to the wishes of the collective, to maintain group harmony. Though such coping mechanisms, perceptions and traits may help elderly Filipino Americans adjust initially to their illnesses. These tactics also pose barriers and impede the implementation of necessary treatment or intervention in a timely fashion (Periyakoil & Dela Cruz, 2010). Sanchez and Gaw (2007) point out that the traditional coping mechanism like “*tiyaga*” (patience and endurance) enables Filipino migrants in America to tolerate uncertain situations. In response to illness,

Filipino migrants rely on their family members' support. They are usually more comfortable discussing their illness and other important matters in the presence of the family. There exists a natural culturally bound aversion to consulting health providers about psychological issues and therefore a decision to seek help must be adequately explored first.

Nadal (2009) describes the importance of indigenous and spiritual counseling methods which are referred to as a system of psychological thought and practice rooted in a particular cultural tradition. It also involves recognising the cultural values, beliefs, and practices of a given group and integrating those practices into mental health treatment.

The Philippines is a Roman Catholic country and 80.9 % of the total population belongs to this religion. Most Filipino women are devoted to their religion and it affects their lives in the host cultural environment. Like Filipinos in America, they seek catholic religious leaders for guidance when dealing with mental and health issues (Nadal, 2009).

Principle of balance, perception of illness, health promotion/treatment concepts, and response to illness are the key beliefs and behaviours of Filipino migrants that have a bigger impact on their health. They have similar impacts on the health of other Asian migrants. Understanding these concepts will assist health care professionals in identifying with the likely behaviours of Filipino women migrants.

### **2.3.2. Access to health care services**

Health care refers to a country's system of delivering services for the prevention and treatment of disease and for the promotion of physical and mental wellbeing (n.a., 2009a). In Australia, health care follows Western traditions in preventing, examining and treating ill health with the use of technical and scientific skills.

People coming to Australia have had health checks before entering the country as a way to keep the nation healthy (n.a., 2006b). Migrants have to undergo a medical check before given a visa to enter Australia. However, they are not given full information about the health and health care system in Australia. Therefore, it is



expected that they will encounter some problems in accessing health services in Australia.

Since the introduction of multiculturalism to Australia, many reports have discussed the health needs of migrants in society (Asghari-Fard & Hossain, 2008). Findings show that migrants access health services less than Australians due to being underserved, language barrier, inappropriateness of the health care system and limited knowledge about the services. As a consequence of medical-cultural issues, new concepts such as, cultural awareness has been introduced to the health care system (Asghari-Fard & Hossain, 2008). Generally, health care systems around the world are struggling to provide quality care for a diverse population.

According to Norredam, Nielsen and Krasnik (2007), the UN Universal Declaration of Human Rights states that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, and housing and medical care" (p. 48). The declaration asserts that access to health care is a human right. In line with this, World Health Organisation (WHO) of 1978 Alma Ata Convention considered universal access to health care as its goal (Norredam, et al., 2007). Several factors can influence migrants' access to health care which includes predisposing factors, enabling factors and needs. Predisposing factors include socio-demographic factors such as ethnic background, sex, age, and race but may also include norms of health help-seeking behaviour among relevant social groups. Enabling factors are migrants ability to pay including insurance cover, and needs are about how ill a person is and how likely that person is to recover (Norredam, et al., 2007). Norredam, Nielsen and Krasnik (2007), further emphasise that migrants' access to health care services in the host country can be influenced by a series of factors. These factors are formal and informal barriers. Formal barriers include the organisation of health care services, such as user charges. In countries where patients and migrants pay for treatment, this can hinder their access to optimal health care services particularly migrants often have poorer socio-economic conditions than the mainstream population. Informal barriers to health care access include language, psychology, and socio-cultural factors (Norredam, et al., 2007).

To migrants like Chinese Americans, income, language and citizenship status are factors that affect their access to health care services (Jang, Lee, & Woo, 1998). However, Natividad (2008) points out that the barriers that need to be overcome in gaining patient participation are:

*...culturally derived health beliefs that are different from those of Western medicine; medical providers' inability to communicate with the patient in the patient's primary language; inability to afford the cost of medical evaluation and treatment, and unfamiliarity with the access points to medical care. (pp. 327-328)*

Among these, communication is the most obvious challenge (Natividad, 2008). Different researchers use different models and concepts to explain the barriers to accessing health care services. Based on the models and existing literature discussed above, language barriers and socio-cultural barriers come up to be the most common barriers in accessing health care services among migrants. Thus, this chapter uses these concepts as a model for describing the barriers of access to health care services faced by most intermarried Filipino women.

### **2.3.2.1. Language barrier**

Like many English speaking countries, Australia has also experienced a dramatic increase in the number of people who are from non-English speaking countries. This language barrier is critical to health care because it is the key for communication and integration. According to Roxon (2009), many migrant women experience a double disadvantage due to lower level of English proficiency than male migrants, which impacts on their ability to access health related information, health services, and more broadly, education, employment and income. Health care providers surveyed in Los Angeles, New York, Houston and Miami have found that the language problem is a major barrier to immigrants' access to health care and a serious threat to the quality of care they receive, since doctors could not get the information needed to make good diagnosis and patients often do not understand their direction (ACORN, 2003). Schyve (2007) in his study *Language Differences as a Barrier to Quality and Safety in Health Care* stresses that:

*The need to communicate effectively was recognised as an element of the quality of patient care. Today, effective communication which takes into account language, cultural differences, and health literacy is seen as a prerequisite to safe health care. Communication problems are the most frequent root cause of serious adverse events reported to the Joint Commission's Sentinel Event Database and a Joint Commission study found that when patients suffer adverse outcomes from medical errors, the outcomes are more serious in limited English proficiency patients than in English-speaking patients. (2007, p. 361)*

Kittler and Sucher (2008) stress that

*...communication uses symbols to represent objects, ideas, or behaviours. Thoughts, emotions, and attitudes are translated into language and non-verbal actions (i.e., gestures, posture, eye contact) to send messages from one person to another. Only the person sending the message knows the meaning of the message: the person receiving the message must use what she knows about cultural and social norms, as well as what she knows about the speaker personally, to interpret the message. (p. 58)*

Stewart and Nam Do (2003) also note in their research about health needs of Vietnamese women in South-Western Brisbane that

*...most of the women in their study expressed concerns regarding their communication skills. Even those who had good English skills indicated that they had continuing problems, as the English used in medical situations requires a high level of English proficiency. (p. 253)*

A study by Jirojwong and Manderson (2001) on Thai women in Brisbane Australia identified that Thai women's inability to communicate effectively in English is an important factor influencing their psychological wellbeing. However, in a recent longitudinal survey of immigrants to Canada conducted by Statistics Canada it was reported that language barrier was a migrant's biggest difficulty next to finding an adequate job. This finding also stressed that after a four year stay in Canada, 26% of

the migrants still reported having English language difficulty (Jirojwong & Manderson, 2001).

For intermarried Filipino women, English language is used as a medium of instruction in the Philippines. Most Filipino women have knowledge about the language. However, their fluency in the language depends on their level of education. It is assumed that the higher the education status, the more competent they are in communicating in English. According to the Semics LLC (2007), study on culture and health among Filipinos and Filipino-Americans in Central Los Angeles in the United States, a common assumption is that, unlike other Asian ethnic and immigrant groups, Filipinos/Filipino Americans can adapt relatively easily to life in America because of the strong presence of English language in the Philippines. However, their findings also reveal that Filipinos/Filipino American immigrants often struggle with the English language, regardless of their familiarity with it. This finding shows that communication with health providers is more problematic than it might appear despite Filipinos'/Filipino Americans' proficiency in English. Therefore findings of Semics LLC (2007), show that being familiar with and having knowledge of English language is not good enough for communicating with health care providers. In Australia, intermarried Filipino migrants who can speak English also have difficulty in communicating with the health care providers, partly due to the Australian accent. Given that Filipino migrants' English is closer to American English and there is still difficulty in communicating with American health care providers, one would expect there should be more language problems facing Filipino migrants in Australia.

Bowen (2001) commented that language barriers have been associated with both higher and lower rates of service utilisation. His analysis of utilisation patterns associated with language fluency indicates that some of the observed differences may be due to differential effects of: a) language barriers to initial access which prevent a person from presenting for assessment and care, and b) communication barriers affecting diagnosis and treatment which affect the quality of care obtained. What Bowen states here is convincing. If intermarried Filipino women migrants cannot explain themselves clearly to the health care professionals, they will not be

given proper help. As Yeo (2004) explains that language is a means by which a patient accesses the health care system, learns about services, and makes decisions about her and his health behaviour. Language is also a means by which a health care provider gets to understand the patient's beliefs about health and illness, and thus creates an opportunity to address and reconcile different belief systems. Clearly, language is the essence of transactional and interpersonal communication.

Bowen (2001) further explains, research indicates that there is a general pattern of lower use of many preventive and screening programs by those facing language barriers. Higher use has been reported for some emergency department services, and for additional tests ordered to compensate for inadequate communication. It is important to note that utilisation may be determined by either the patient or the provider. The patient most often initiates the first contact with the health system. However, referral for specialist consultation; diagnostic testing, return visits or prescription of pharmaceuticals are determined by the health care provider. Even participation in preventive programs may be physician-initiated (rather than patient-initiated) through the course of a routine or other visit.

Allotey et al. (1999) points out that other common issues migrants face in accessing health care services include: difficulties in making initial contact, cultural issues associated with asking questions, practical constraints and differing perceptions of health risks. Some Filipinos may feel that doctors do not provide enough information or explain alternative forms of treatment, and these people may switch doctors fairly regularly. Here is a very common example of this situation:

*When a patient is hospitalised it is often worthwhile for a familiar person, such as a husband or friend, to be present to help to explain diagnoses or procedures. Having familiar people present will help approximate the continuing family care which would occur in a Filipino hospital. Standard isolation procedures, such as isolation rooms, visitors restriction and barrier nursing, may be unfamiliar to Filipino patients and cause anxiety. Therefore the procedures should be clearly explained to the patient, friends and*

*relatives. If possible, a patient may like to have a companion with them at all times to help reduce any anxiety. (Allotey, et al., 1999, p. 4)*

#### **2.3.2.2. Cultural barrier**

Cultural barrier complicates the delivery of health care and migrants' health in general. In Uba's (1992) study *Cultural Barriers to Health Care for Southeast Asian Refugees*, she identified different cultural issues affecting migrants: attitude toward suffering, etiology of illness, distrust of western medicine, unfamiliarity with western medical methods, lack of bilingual members, health care providers' cultural ignorance, poor communication between physician and patient, culturally irrelevant services, misinterpreting the side effects of folk medicine, inaccessibility of services, difficulties accessing services, lack of financial resources, and geographic inaccessibility of services.

Pacheco (2003) studied culture and health of foreign-born immigrants where he explored the connection between culture and health by analysing information from a sample of foreign-born Chinese, Filipinos, and Vietnamese through their cultures, health beliefs, attitudes, values, behaviour and experiences. The findings of this study stress the importance of culturally appropriate and competent quality health care for patients who are cultural minorities.

According to Le (1999), cultural difference is considered as the most important factor contributing to miscommunication as it covers many communicative aspects already existing in an intercultural context in addition to a vast ocean of differences between cultures. Cultural difference presents major barriers to effective health care intervention. This is especially true when health care professionals overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those, who might be viewed as different from them, in their assessment, interventions and evaluation planning processes (Huff & Kline, 1999).

Culture is the ways of living and functioning in society. These ways and values differ from culture to culture. To function effectively in a particular culture, an individual needs to know how to behave appropriately according to cultural expectations.

Every individual learns the norms of their own culture as a matter of course, beginning at birth and continuing throughout life. As a result, the norms are rooted in their sub-consciousness, enabling them to react to familiar situations without thinking. However, when they get involved in another culture with different norms, problems begin to arise. Like in Easteal's (1996) study, a South Australian legal practitioner commented that, "language and cultural barriers often make it more difficult to access and understand information and therefore reinforce fears, hopelessness and isolation" (p. 28). This statement reflects the common Filipino women behaviour especially if they originate from rural areas of the Philippines and now also live in rural parts of Australia.

In Hoang's (2008) study of Asian migrants in rural Tasmania, her findings reveal that Asian migrants in Tasmania (which includes Filipino women) face language and cultural barriers when dealing with the new health care system. Because some Asian migrants retain traditional views and practices for maternity care, confusion and conflicting expectations have occurred. Ludwig-Beymer (2008) also explained that:

*An individual's culture affects access to care and health seeking behaviour, as well as perceived quality of care. In addition to understanding the culture of patients or clients, however, it is also essential to examine the culture of provider's organisations. The interplay of client, provider, and organisational cultures may create barriers, because cultural conflicts, lead to a client's lack of trust or reluctance to access services, and may ultimately result in health care inequities. (p. 197)*

Pottie (2007) however, explained that language and cultural barriers can have adverse effects on accessibility of care, quality of care, patient satisfaction, and health outcomes. Communication is considered one of the most important prerequisites for safety in health care. Studies have clearly demonstrated that lack of language proficiency is associated with poor access to health services and preventive services. Language barriers also contribute to the inability to book appointments or to follow advice on prescriptions, and contribute to overall poorer

quality and poorer outcomes of care (Pottie, 2007). Thus, it is attested that these two factors have a great impact on migrants' access to health care services which creates health problems to migrants.

The overall health picture reflects the important health disparities that exist among poor and more vulnerable populations. As a result of language and cultural barriers, as well as a lack of information about the new health care system, the health of new comers declines over time.

### **2.3.3. Health problems**

Filipino migrants' views, concepts and attitudes towards health and the barriers that affect their access to health care services such as language and cultural differences complicate the delivery of health care and their health in general. Most of the studies focused mainly on a specific health issues and were conducted in the United States.

Yamada, Caballero, Matsunaga, Agustin and Magana (1999) studied Filipino's knowledge, attitudes, and practices concerning tuberculosis (TB) in which four groups of Filipino immigrants were convened to discuss explanatory models regarding TB. The findings state that the focus group participants expressed a belief in the extreme contagiousness of TB which leads to social stigma and isolation. The desire to avoid such consequences leads some to deny their illness, not to seek attention, or to attempt to hide their illness. While all agreed that biomedical treatment is necessary, many believed in the effectiveness of traditional and popular treatments.

According to Sanchez and Gaw (2007) in their study of Mental Health Care of Filipino Americans, there exists a dearth of information on mental health issues concerning Filipino Americans, who represent a diverse mixture of culture, beliefs, and practices and vary widely from other minorities as well as from the larger population. This group has experienced emotional and behavioural challenges in acclimatising to Western culture. Their historical underpinnings, native core values, and traditions exert a crucial influence on their mental wellbeing. Filipino Americans



underutilise existing mental health care services that are culturally, socially, and linguistically incompatible with their needs. Along with stigma, adherence to traditional practices and healing methods remains a formidable barrier for the appropriate provision of care.

However, Becker (2003) investigated the Cultural Expressions of Bodily Awareness among Chronically Ill Filipino Americans. His findings show that the concept of balance is central to Filipino Americans' awareness of bodily signs and symptoms related to chronic illnesses, as well as to actions they take to manage their chronic illnesses. Efforts are made to control chronic illnesses through a variety of self-care practices. Diet poses a particular challenge because of the symbolic importance of food in Filipino culture and its use in the maintenance of social relationships. The findings of Yamada et al. (1999), Sanchez and Gaw (2007) and Becker (2003) illustrate the strong impact of Filipinos' knowledge, attitudes and practices or culture in general towards certain illnesses.

Several studies have also been conducted around the globe regarding Filipino migrants' health issues. Fernandez (2001) studied the health concerns of Filipino migrant workers in Malaysia; Rispen-Noel (1997) investigated the issues and concerns of Filipino migrants in the Netherlands where they conducted a forum and attracted participation of all Filipino migrant organisations in the Netherlands. The purpose was to "bring to the attention of the Dutch and Philippine governments, social institutions, and non-profit organisations the problems and concerns of Filipino migrants in the Netherlands" (1997, p. 1). In the U.S., Wolf (1997) focused on transnational struggles among children of Filipino immigrants. In his study some of the issues and problems confronting second generation Filipino youth were given importance.

In Australia, Kelaher, Williams and Manderson (2001) studied the population characteristics, health and social issues among Filipino women in Queensland and explored the impact of immigration experience, employment, social support, relationship issues and use of health services on the health and wellbeing of 482 Philippines-born women in the state of Queensland.

Kelaher, Potts and Manderson (2001) examined the Filipino women living in remote and rural environments in Queensland. The study emphasises that the transition from a newcomer to an old-timer is more difficult for Filipino women than for other rural women because they are visibly different from other members of the community and suffer from stigmatisation associated with the perceptions that they are mostly mail order brides. Research findings show that Filipino women's concerns about confidentiality and a reluctance to ask for support are major barriers to health service utilisation. The area of greatest concern is mental health, particularly in relation to parenting issues. Improving access may involve providing a greater awareness of what services are available and allowing women to access services in a way that does not require them to label themselves or to be labeled by others.

Alati, Najman and Williams (2004) also studied the mental health of a cohort of Filipino and Australian-born women who became mothers in Australia, and investigated the relationship between place of birth, social network size and symptoms of poor mental health. In this study Alati et al. (2004) found that aside from high education and occupation status, age differences between the Filipino-born mothers and their partners and smaller social networks were some of the factors believed to trigger mental health problems. Incidents of anxiety and depression experienced by Filipino-born mothers emerged as higher than those of Australian-born mothers. However, over time reported symptoms of anxiety and depression in Filipino-born mothers appeared to decline and harmonise with the rate experienced by Australian-born mothers.

However, Allotey et al. (1999) point out that major health issues faced by Filipinos in Australia consist of problems associated with adopting a more Australian lifestyle, including alcohol consumption and smoking, reproductive health problems, particularly those associated with late pregnancy and a relatively short gap between child bearing and onset of menopause, gambling, social problems such as poverty and domestic violence, and mental health problems. To date, very little research has been conducted on health issues of intermarried Filipino women in Australia particularly in Tasmania, since most of the research is conducted in Queensland,

Melbourne, Sydney and Canberra. Hence, this research will fill the gap in the existing literature. Health should be treated as a priority in research because it deals with the fundamental aspect of life. Ghent (2008) reported that according to Dr Daniel López-Acuña (Director of WHO's Action in Crises Recovery and Transition Programmes): "[Migrant health issues are] now coming to a head in some countries, which is why they have been raised at the highest levels within the public health agenda at national and international health levels" (p. 583).

Attention has been paid to research on different types of health issues concerning other migrants. These research findings are important in this review because migrants' especially Asian migrants very often share common experiences. Lee and Pacheco (2003) studied the culture and health of foreign-born immigrants. He explored the connection between culture and health by analysing information such as culture and health beliefs, attitudes, values, behaviour and experiences from a sample of foreign-born Chinese, Filipinos and Vietnamese. The findings of this study provide insights into culturally appropriate and competent quality health care for minority patients. Le and Le (2005) examined the ways in which Vietnamese migrants in Australia perceive various aspects of health issues such as treatment, health care, role of health workers and interpersonal relationship between patients, family members and health workers. The results of this study provide useful insights into health problems facing people of different socio-economic backgrounds. It also contributes a great deal to the understanding of the cultural diversity of Australia. Allan (1998) attempted to identify explanatory models of overweight issues among African American, Euro-American, and Mexican American women. Pobutsky et al. (2005) studied Micronesian migrants in Hawaii with a focus on health issues and culturally appropriate community-based solutions. Micronesians have migrated to Hawaii for reasons of limited economic resources, inadequate educational system, scant job opportunities, high rates of infectious diseases and a struggling health care system in their native land. Pobutsky et al. (2005) provided information on how the Micronesian migrants should be helped in Hawaii by adopting "community-based approaches to change" such as enhancing community engagement, outreach and networking. Community leaders organise a series of community meetings and

encourage the participants to voice out their most important needs, In that case Hawaii is able to determine how best to create or use existing resources to alleviate migrant problems.

## **2.4. Intermarried Filipino women's wellbeing**

### **2.4.1. Defining wellbeing**

There is no single agreed definition of wellbeing (Newton, 2007). Wellbeing depends on all the factors that interact within culture and can be seen as a state of health or sufficiency in all aspects of life (Trewin, 2001). However, there are many definitions of wellbeing based on people's experiences or how an individual embraces it. At the individual level, this includes the physical, emotional, psychological and spiritual aspects of life. At a broader level, the social, material and natural environments surrounding each individual, through interdependency, become part of the wellbeing equation (Trewin, 2001). Hence, some authors define wellbeing in two ways: objective and subjective wellbeing. Objective wellbeing refers to the material and social circumstances believed to impact an individual's or a community's sense of wellbeing. This may include income, housing, educational attainment, access to and use of public services and so forth (Ashcroft & Lynas, 2008). While subjective wellbeing is about how people evaluate their lives. People can do so in terms of a global judgment such as satisfaction or in terms of evaluating certain areas of their lives such as marriage or work, or in terms of their ongoing emotional feelings about what is happening to them (Ashcroft & Lynas, 2008).

Felce and Perry (1995) describe wellbeing as consists of objective descriptors and subjective evaluations of physical, material, social and emotional wellbeing, together with the extent of personal development and purposeful activity, all weighted by a personal set of values. However, Ryan and Deci (2001) view wellbeing as derived from two general perspectives: the hedonic approach which focuses on happiness and thus they consider wellbeing in terms of pleasure attainment and pain avoidance; the eudaemonic approach which focuses on meaning and

realisation and defines wellbeing in terms of the degree to which a person is fully functioning. These two views have given rise to different research foci and a body of knowledge that is in some areas divergent and in others complementary.

In this research, wellbeing is examined in four dimensions as based on the article “What is Wellbeing” (HOOAH 4 HEALTH, 2007)

The physical state centres on one’s health and sense of wellness, satisfying physical needs through a healthy lifestyle.

- The material state centres on essential needs such as shelter, food, and financial resources.
- The mental state centres on the needs to learn, grow, achieve recognition, and be accepted.
- The spiritual state centres on a person’s religious/philosophical needs and may provide powerful support for values, morals, strength of character, and endurance in difficult and dangerous circumstances.

The four dimensions of wellbeing are very important for intermarried women migrants and most especially for intermarried Filipino women. Each aspect of the wellbeing dimensions plays a vital role in the intermarried Filipino women’s lives affecting how they could acculturate themselves to their new homeland physically, materially, mentally and spiritually. This means that they tend to give the totality of themselves in order to achieve wellness. If all these dimensions work well together, there will be a sense of wellbeing and the intermarried Filipino women will be more equipped to deal with various problems and stresses in life. However, as they engage in daily activities in the new environment, they will discover different factors which could affect their ways of settling into the new environment as well as their wellbeing.

### **2.4.2. Wellbeing issues**

Several wellbeing issues identified in the literature are described mainly in broader terms such as physical, emotional, psychological, spiritual, social, and material issues. Yet this study aims to classify the wellbeing issues to specific and common issues. The purpose of classifying these issues into specific and common issues is to show how they are viewed and valued in the reviewed literature. Hence classifying these issues into these categories will also identify the gaps this current study attempts to address. The specific wellbeing issues relevant to intermarried Filipino women are: familiarity with mainstream Australian culture, educational background and stereotyping of intermarried Filipino women.

#### **2.4.2.1. Familiarity with mainstream Australian culture**

The Filipino life has been strongly influenced by its traditional culture and Western cultures. Historically Spain and the U.S. took turns in occupying the Philippines for a substantial period of time. Their influences are clearly reflected in music, religion, government, food and sport. However there is a strong traditional Filipino culture which is still very much deeply rooted in the hearts and minds of Filipino people. This includes such as strong family solidarity, close community with a collective spirit, world views and spiritual belief (Burma, 1951; Cornell & Hartmann, 1998).

It is possible that conflicts may arise when intermarried Filipino women live in a main-stream Australian cultural environment. For instance, they tend to expect their children to devote more time to them and provide financial assistance when they get older. Their children, particularly those who have little contact with Filipino communities, may be brought up and educated with values and worldviews quite different from their mothers'. Such discrepancy can lead to unhealthy relationship between Filipino wives, their husbands and children, affecting particularly the emotional life of Filipino women. Alba and Nee (1999) assert that both immigrant and mainstream cultures influence one another. Integration is not a one-way path, but rather an interaction between two societies. An immigrant is substantially changed through the migration process by learning a new language, acceptable behaviour, new cultural knowledge and values which shape daily interaction,

particularly that of individualism and protestant work ethic. In contrary, mainstream culture maybe influenced on less significant matters, such as food or the occasional culture fests, which can facilitate the continued stereotypes of immigrants as “exotic” and “the other” (Reyes, 2006).

#### **2.4.2.2. Educational background**

Filipinos have a high regard for education, which they view as a primary avenue for upward social and economic mobility (Dolan, 1991). “Education is meaningful and relevant which equips people with knowledge and skills for daily living, increases opportunities for income and job security, provides people with a sense of control over life circumstances and enables them to participate in society” (Lloyd, et al., 2004, p. 50). However, Berry (1997), pointed out that well-educated migrants likely experienced:

*...a combination of status loss and limited mobility. Once one's 'departure status' is frequently higher than one's 'entry status'; credentials (educational and work experience) are frequently devalued on arrival. Sometimes this is due to real differences in qualifications, but it may also be due to ignorance and/or prejudice in the society of settlement, leading to status loss, and the risk of stress. (p. 22)*

In many cases, Filipino wives are more educated than their Australian husbands. The gap between the educational levels of Filipino wives and their Australian husbands can be detrimental to their relationship and understanding. Filipino wives may prefer academically orientated activities such as visiting a library or a museum, whereas their husbands may prefer social activities such as attending a wood-chopping carnivals or drinking at a local pubs with their mates.

The wellbeing and health status of migrants will improve along with the levels of education and literacy. Like in the case of children and adolescents with low levels of education, they are more likely to suffer poor health and wellbeing as adults. Thus educational attainment is strongly associated with occupation and income level. Poor social circumstances in early life are associated with low levels of

academic achievement (Lloyd, et al., 2004). Lloyd, Newell and Dietrich (2004) has emphasised that:

*Appropriate education protects and promotes health by providing an environment and culture which is safe, healthy and conducive to learning. Appropriate education is likely to lead to direct health gains through the adoption of health promoting behaviours and indirectly by providing access to employment opportunities and life chances that can protect individuals from being disadvantaged. (p. 52)*

Therefore educated migrants or educated intermarried Filipino women are able to deal with life circumstances better as compared to those who are not well-educated in the host country. Berry (1997) also points out:

*Education appears as a consistent factor associated with positive adaptations: higher education is predictive of lower stress. A number of reasons have been suggested for this relationship. First, education is a personal resource in itself: problem analysis and problem solving are usually instilled by formal education and likely contribute to better adaptation. Second, education is a correlate of other resources, such as income, occupational status, support networks etc., all of which are themselves protective factors. Third, for many migrants, education may attune them to features of the society into which they settle; it is a kind of pre-acculturation to the language, history, values, and norms of the new culture. (p. 22)*

Education is a fundamental determinant of socioeconomic status and a crucial determinant of health, employment and income. According to Roxon (2009) higher levels of education provide better employment opportunities and higher income. Thus, it can provide knowledge and skills necessary to access health services and to live a healthy lifestyle.

#### **2.4.2.3. Stereotyping of intermarried Filipino women**

Numerous research in Australia on intermarried Filipino women deals with negative themes such as exploitation, trafficking, domestic violence, etc. One of the main



reasons for this is the stereotyping of Filipino women as mail-order-brides which makes them prone to unfortunate circumstances such as violence. Schneider (2004) emphasises that the term stereotypes are commonly referred to a person's characteristics on the basis of their nationality, ethnic, or gender groups. Schneider (2004) further explains that stereotypes are a salient part of culture and has been represented on television and in the movies. Sometimes parents, teachers and other socialisation agents consciously or unconsciously address them under guise of conveying the wisdom of age. Therefore they are part of the cultural air that everyone breathes.

*Stereotypes are explicitly assumed not only that they are products of cultures, but that generalisations about groups of people can be stereotypes only if they are widely held. These two assumptions feed off one another. If stereotypes are a part of the general culture, it would be bit strange if they were not generally believed. Cultural beliefs and values are, almost by definition, widely accepted. At the same time, if a large number of people hold the same beliefs, the easiest (but not, as we shall see, the only) explanation is that they have been subjected to the same cultural tuition.*  
(Schneider, 2004, p. 321)

As the number of intermarried Filipino women increases, so too does the number of them being prone to danger. According to Ethnic Affairs Commission of NSW as pointed out by Saroca (2006) in her study regarding Filipino women migrants, Filipino women in interracial marriages are often misunderstood because of the media's portrayal of them as mail-order-brides, sex objects and prostitutes which gives negative perception of all Filipino women, their migration and their settlement in Australia. These so-called miss-conceptions of the images of the Filipino women as being submissive and sexual depicted the women to being vulnerable to male abuse. Filipino women in Australia are almost six times more likely to be victims of homicide than other Australian women (Saroca, 2006).

Another reason for stereotyping and misunderstanding Filipino women in interracial marriages is the "different expectations and lack of understanding of cultural

differences” (Mowatt & Wall, 1992, p. 1). Bernard (1998) explains that men and women have different expectations and experience different reality within the same marriage and this contributes to marital conflicts. Bernard (1998) further explain that this concept is applicable to cross-cultural marriages, where one partner’s expectations of marriage and gender roles may be in conflict with the other because of the different traditions and values held. For example in the Filipino tradition, a wife has to serve her husband. This can be a source of abuse or misunderstanding in intermarriage.

According to Chin and Bigby (2003) like other non-white groups in the United States, Asian Americans have been exposed to racism and derogatory stereotypes. Asians have often been portrayed as immoral and inferior to those in the West if not subhuman (e.g., images portraying Asian women as prostitutes), creating perceptions of Asians as primitive, heathen, and hedonistic (Chin & Bigby, 2003). In the opinion of some, these negative stereotypes made it easier for the United States during World War II to justify the internment of Japanese American citizens and the dropping of an atomic bomb on Hiroshima (Chin & Bigby, 2003).

#### **2.4.2.4. Acculturation**

Acculturation is the most common issue facing immigrants/migrants. It refers to changes resulting from migration, colonisation and other forms of intercultural encounters (Berry & Sam, 1997). In its original level of concept, acculturation is a change of culture of the group; in the latter, acculturation is a change in the psychology of the individual (Berry, 1997). Thus, acculturation is an issue that affects migrant health. When presented with varying systems of knowledge, values, beliefs and behaviours, migrants experience conflicts and will need to change their system of meanings in order to conform to a dominating culture (Spardley, 1979). Migrants who experience different value systems when they migrate to new countries may undergo a process of change in their values and habits to adapt to the new cultural environment. When groups of migrants having different cultures come into continuous first-hand contact, subsequent changes in the original culture

patterns of either or both groups may be affected. Therefore acculturation encompasses both phenomena (Berry & Sam, 1997).

Acculturation of migrants has received great attention in research. Many of the findings deal with the psychological and social aspects. These findings pave the way for steps that can be taken to “make positive adaptation more likely” (Berry, 1992, p. 69). In this study, five factors were examined to determine their effects on intermarried Filipino women’s acculturation and their impact on their general wellbeing namely: interpersonal relationship and social networking, linguistic issues, cultural shock, migration issues, and marital issues.

#### *2.4.2.4.1. Interpersonal relationship and social networking*

Interpersonal relationship is a major component of the Filipino core value *kapwa*. It is defined as shared identity, interacting on an equal basis with a fellow human being. It is expressed as sensitivity and regard for others, respect and concern, helping out, understanding and making up for others’ limitations, rapport and acceptance, and comradeship (Agoncillo & Guerrero, 1987; McBride, n.d.). However, social networking is making a connection with people whom one knows and with whom one feels connected (Videbeck, 2010). Interpersonal relationship and social networking is so important that it affects the acculturation process of intermarried Filipino women particularly in terms of self-esteem and confidence. As noted, Filipino women often have and need of a close family tie. This factor includes having a good relationship with the in-laws (husband’s family), relationship with family back home, relationship with local Australians and relationship with the community. According to Bollini and Siem (1995) the absence of close family ties or interruption in social support has been identified as common stressors encountered when migrating to a new country. Thus, the level of social support a migrant receives influences the way they adapt to their new country. It is important to have an appropriate level of support from family or friends as they are a source of pleasure, belongingness and companionship that can buffer stress (Adams & Blieszner, 1995). Videbeck (2010) pointed out, evidence have found that having social network can help reduce stress, diminish illness, and positively influence

one's ability to cope and to adapt life circumstances. Courtright (2005) emphasises that strong ties with family members help migrants resolve problems and locate health care services. People need supportive, positive relationships and a sense of social belonging to sustain wellbeing (Ashcroft & Lynas, 2008). According to Courtright (2005), migrants would consult family members for health problems. Their relatives offer advice and home remedies over the telephone; and relatives who arrived earlier serve as guides to local resources or serve to help find volunteers who could help.

Social networking plays an important role in the life of intermarried Filipino women in Australia. As stated, Filipino women are strongly family-orientated in the sense that family members support one another mentally, emotionally and financially regardless of age, gender and social status. Thus, while Filipino women are living with their children and husbands in Australia, they still maintain strong family ties with their families in the Philippines. According to Smith (2004), "support from families and friends and communities helps people solve problems, deal with adversity and maintain a sense of mastery and control over their life circumstances; mutual trust and respect in the community protect people and their health" (pp. 70-71). Thus, this kind of support likely decreases potential mental health risk. In contrast, the absence of family and close friends can result in anxiety and depression. Evidence imply that people or migrants with having good social support network lives longer, at a minimal risk of cardiovascular disease and infectious diseases , are less likely to experience depression than those with poor social networks (Lloyd, et al., 2004).

Intermarried Filipino women value relationships among their peer groups or barkada. Filipina (a.k.a Filipino women) are seldom seen alone and are usually found in clusters especially in public places. Individual preferences are overshadowed by group choices. Time spent with friends and peers also serves as a time-out from the pressure of family obligations (Shapiro, 2002). Thus, migrants who are able to build new friendship with the mainstream, can maintain some level of social support with friends and will be able to adapt better and experience less stress compared to those who cannot (Jehobo, 2001).

Filipino women and their families in Australia have established different social organisation to stay connected and promote social networking among each other. In fact, there are about 14 Filipino community organisations in NSW/ACT, 26 in Victoria, 5 in Queensland, 2 in Western Australia, 2 in South Australia and 3 in Tasmania (Filipino Australian Business Directory 2008 FILOPAGES). These organisations tend to be more active in big cities. For those living in remote and rural Australia, social networking with other Filipino women is very weak (FILOPAGES, 2008). Most particularly for those Filipino women who are “mahiyain” (shy) they prefer not to socialise with other people apart from family members and close friends. This social isolation can be detrimental to their wellbeing, especially when living in a new cultural environment. Some intermarried Filipino women endure a violent relationship because of the cultural value *hiya*; they are ashamed of letting people know about what is happening to them and they are also afraid of more violence (Abano, 2006).

#### 2.4.2.4.2. *Linguistic aspect*

The Philippines is a multilingual country with 87 related Austronesian languages of the Malayo-Polynesian sub-group of that family, which also includes Indonesian and Malay (Clyne & Kipp, 2005). The most widely spoken languages in the Philippines are: Tagalog, Cebuano, Ilocano, and Hiligaynon (Clyne & Kipp, 2005). Because of the language diversity, intermarried Filipino women or Filipino migrants may have difficulty in communicating with their fellow Filipinos, especially for those who cannot speak the national language or English. Therefore the language of the host country is important.

Halliday's (1994) theory of language provides a very comprehensive view of language and its social functions. Halliday (1994) explains that people know what language is because they know what language can do for them in real life. Thus one can argue that the limit of our language is the limit of our world. This statement infers that when Filipino women come to Australia, they can be disadvantaged if their knowledge of English is very limited. Their limited English can confine them to a narrow domain of social interaction, mainly with their respective Australian

spouses and families. As language is fundamental to communication and interpersonal relationships, Filipino women with little English could be placed in a socially isolated cell and this could lead to over-dependence on their husbands. These Filipino women are used to a social environment in the Philippines where they live and share their feelings and thoughts daily through verbal interaction. The lack of social interaction in the Australian context can be detrimental to their wellbeing and health.

English is commonly known as a universal language. As Bowen (2001) described, English is the language of commerce, instruction and almost all daily exchanges in Australia. Therefore, proficiency in English is clearly an important indicator of the ability of an immigrant to participate fully in Australian society. However, the use of English language differs in every country and in every culture. Chin and Bigby (2003) in their study has comprehensively explained the differences:

*Culturally specific communications are apparent in the tendency and value placed on concise and indirect communication. In writing, brevity is valued as an indication of scholarship; emphasis is placed on the use of metaphor and nuances in meaning. Whereas Western values stress getting one's points across, Asian values stress politeness in verbal discourse. As a result, Westerners typically value verbal fluency, whereas Asians typically value not showing overt disagreement. Asian cultures, defined as high-context cultures, rely more on non-verbal context for information than on verbal context. Asians are commonly known to resort to indirect communication to an art form. (p. 136)*

The language differences explain by Chin and Bigby (2003) clearly describes the common reason of the language barrier experienced by intermarried Filipino women and other Asian migrants.

#### **2.4.2.4.3. Cultural shocks**

Culture shock is the most common wellbeing issue facing migrants. The term, culture shock, was introduced for the first time in 1958 to describe the anxiety

produced when a person moves to a completely new environment (Guanipa, 1998). This term expresses the lack of direction, the feeling of not knowing what to do or how to do things in a new environment, and not knowing what is appropriate or inappropriate. The feeling of culture shock generally sets in after the first few weeks of coming to a new place (Guanipa, 1998). In general terms, culture shock is described as the adjustment process in an individual's emotional, psychological, behavioural, cognitive and physiological state of being (Pedersen, 1995). In a multicultural context, culture shock is a sudden immersion into a nonspecific state of uncertainty where the individuals are not certain of what is expected of them or of what they can expect from the persons around them (Pedersen, 1995).

Pederson (1995) identifies six indicators of culture shock which most migrants have experienced:

1. Familiar cues about how the person is supposed to behave are missing, or familiar cues now have a different meaning;
2. The values that the person considered good, desirable, beautiful, and valuable are no longer respected by the host culture;
3. Disorientation of culture creates an emotional state of anxiety, depression or hostility, ranging from a mild uneasiness to furies of unreasonable and uncontrollable rage;
4. Dissatisfaction with the new ways and an idealisation of the way things were;
5. Recovery skills that used to work before no longer seem to work;
6. There is a sense that this culture shock discrepancy is permanent and will never go away.

The six indicators of culture shock describe "the physical and emotional discomfort one suffers when coming to live in another country or a place different from the place of origin" (Guanipa, 1998, p. 1). Often, the way that we lived before is not

accepted as or considered as normal in the new place. Everything is different, for example, not speaking the language, not knowing how to use banking machines, not knowing how to use the telephone and so forth. Culture shock is likely to occur to intermarried Filipino women in their first few months in rural Tasmania.

#### 2.4.2.4.4. *Migration issues*

Migration is stressful and generally requires major adaptation, as people cross interpersonal, socio-economic, cultural and geographic boundaries (IOM, 2004). It demands emotional, social, cultural, educational and economic adjustments (Thomas, 1995). Following the arrival at a new cultural environment, a migrant experiences a variety of challenges that result from the process of resettlement and integration (Gushulak & MacPherson, 2006). Such challenges include anxiety, grief, loss, confusion and family separation. Not surprisingly these obstacles can be greater for vulnerable migrant cohorts, and some of them are associated with increased risks that can affect health (Gushulak & MacPherson, 2006). Even a carefully planned move involves redefinition of identity and value systems, with frequent loss of support and disempowerment for foreigners in the new community (IOM, 2004).

Migration is an ongoing process. Migrants do not know when and where they are actually acculturated. Therefore this is an issue that needs attention. Norredam et. al., (2007) suggest that:

*.... it is important to take into account circumstances before, during, and after arrival in the country of destination. Moreover, there is no clear definition of when a person stops being a migrant and becomes a part of the majority population. Factors related to migration can predispose a person to illness. These factors are again related to circumstances before, during, and after migration. Before migration, the migrant might have experienced torture, serious illness, or poor access to health services. The physical migration journey itself might have been dangerous, if, for example, it took place under conditions of avoiding the authorities (illegal trafficking) or having difficulty in accessing health care. In the country of destination, a*



*series of formal or informal barriers to access to health services could contribute to the worsening of the health of migrants. (p. 48)*

#### **2.4.2.4.5. Marital issues**

Marital issues identified in this review are those involving interracial marriages. Interracial marriage itself is a sensitive issue because it concerns the course of race relations (Tinker, 1984). According to Yancey and Lewis (2009), interracial marriages have been problematic and openly criticised throughout American history. Even among white European ethnic groups, an interethnic marriage was initially seen as a very negative occurrence. Therefore interracial marriage represents a major barrier between groups aiming to keep themselves socially and spatially separated.

Recent studies show that financial expectations, issues related to remittance of money to families in the Philippines, the husband's disapproval of his wife's participation in the workforce, and financial practices such as the management of the household finances and roles with money are the causes of marital conflicts between Filipino-Australian couples (Woelz-Stirling, Manderson, Kelaher, & Gordon, 2000). However in Jabar's (2006) study, he finds that the different sources of marital issues are: personality/attitudinal clashes; economic related issues; differences in cultural practices; deferential gender roles expectations; behavior; and lastly communication problems. Shute and Spitsberg (2003) identify that the most common causes of distress in some intercultural couples include: food, religion, sex and gender roles. Based on the findings of these researchers, marital conflicts therefore vary. Even intermarried Filipino women themselves have different experiences and issues to face. Marital issues affect the intermarried Filipino women's wellbeing mentally and emotionally because it hinders their ability to establish a lasting relationship with their husband.

Mowatt and Wall (1992) also point out some problems that relate to different expectations of marriage due to cultural values, including attitudes to the family and extended family. A Filipino wife, for example, may expect to provide some financial support to needy family members; expect her parents, if they are in Australia, to live with her; expect to socialise with family and friends; and anticipate

speaking her community language. Other differences relate to the care of the children, religious practice, financial management and food. Unfamiliarity with Australian lifestyle and possibilities in isolation in the suburbs, lack of employment, the husband's opposition to his wife working, non-recognition of qualifications and lack of appropriate child care, are settlement issues experienced by some (Mowatt and Wall, 1992).

Alongside all these marital conflicts, "couples in intercultural marriages usually enter the process of cultural transition that allows them to adjust toward an adaptive and flexible view of cultural differences, thereby making it plausible to maintain individual values and to negotiate conflicting areas" (Jabar, 2006, p. 45).

The acculturation factors such as: interpersonal relationship and social networking; linguistic issues; culture shock; migration issues and marital issues therefore explain that cultural distance (how dissimilar the two cultures are in language, religion, etc.), lies not uniquely in the background of the acculturating individual but in the dissimilarity between the two cultures in contact. A general tendency is that the greater the cultural difference is, the less positive the adaptation will be (Berry, 1997).

## **2.5. Conclusion**

In this chapter, the researcher critically synthesises relevant information concerning the health and wellbeing issues of Filipino women migrants and some Asian migrants as they share common experiences, beliefs and concepts of health. Drawn from the existing literature and a wide range of documents available, as well as from the researcher's long interaction with members of the Filipino women community especially in Launceston, Tasmania, and her knowledge of Filipino culture, beliefs and health practices, this research is able to critically review the most relevant and most recent information in order to fill in the gaps identified.

Interracial marriage is the most common reason for Filipino women migrating to Australia. They come to Australia to live with their Australian husbands and hope for a better future and a lasting relationship. However, interracial marriage itself is a

hurdle to overcome because it involves interaction of different people of different races and of different culture. Intermarried Filipino women in their quest to live happily in their new home have encountered difficulties particularly in acculturation which in turn influences their health and wellbeing. For the intermarried Filipino women, health is their wealth; therefore it is important to have good health and stay well in their new home in order to face day to day life issues as they interact with their new cultural environment and mainstream Australians.

For the intermarried Filipino women, every day is a journey and a challenge to face, which requires full effort to adjust and emotional intelligence, to handle various problems such as personal and social issues which affect their health and wellbeing. Health of migrants depends on the way they live in the host culture. If migrants can easily adopt the new way of living, the society and the culture as a whole, the better it is for their health as well as for their wellbeing.

# **Chapter 3 – Methodology**

## **3.1. Introduction**

The quality of research depends on the methodology used in a study. As methodology is essential in research, it is important that the methodology of this study is explained in details. According to van Manen (1990), methodology refers to the philosophical framework and fundamental assumptions of research. Because the philosophical framework one uses influences the procedures of research, thus, this chapter explains the methods and procedures applied in this study which covers the following aspects: (a) research design which involves the methodological procedures such as quantitative approach where quantitative data collection and procedure, and data analysis are explained; qualitative approach where the qualitative data collection and procedure, and data analysis are discussed; (b) reliability and validity issues of both approaches are separately discussed to show distinction and its usefulness; (c) ethical issues relating to the conduct of this study; and lastly (d) describing of research limitations.

## **3.2. Research design**

As there is a close relationship between research purpose and methodology in a research project, it is important to briefly state the aim and objectives of this research project before discussing the methodological aspects of this study. This study is primarily aimed to investigate the relationship between health and wellbeing of intermarried Filipino women in rural Tasmania, and their access to and the use of health care services. Four main research objectives are set for this study:

1. To examine the acculturation problems facing intermarried Filipino women in rural and regional Tasmania;

2. To understand the health concepts held by intermarried Filipino women and to examine the views of intermarried Filipino women about their health and health care in rural and regional Tasmania;
3. To identify problems facing intermarried Filipino women in accessing health care in rural and regional Tasmania; and
4. To identify the social and cultural capitals which enhance the wellbeing of intermarried Filipino women in rural and regional Tasmania.

The following section will discuss in details aspects of research methodology which are essential for achieving the aim and objectives of this study.

Research design involves organising and performing a research project - from identifying the problem through to reporting and publishing the results (Punch, 1998). Prior to the conduction of research it is important to consider the three approaches to research which are widely used in population health research. They are quantitative, qualitative and mixed methods approaches. *Quantitative approach* focuses on scientific empirical sources and tools for understanding and developing knowledge (i.e., cause and effect thinking, reduction to specific variables and hypotheses and questions, use of measurement and observation, and the test of theories). It employs strategies of inquiry such as experiments and surveys, and collects data on predetermined instruments that yield statistical (Creswell, Plano Clark, Gutmann, & Hanson, 2003). *Qualitative approach* often makes knowledge claims based primarily on interpretive perspectives (i.e., the multiple meanings of individual experiences socially and historically constructed, with an intent of developing a theory of pattern) or advocacy/participatory perspectives (i.e., political, issue-oriented, collaborative, or change-oriented or both (Creswell, et al., 2003). *Mixed methods approach* involves normally both qualitative and quantitative methods. It employs strategies of inquiry that involve collecting data either simultaneously or sequentially to best understand research problems (Creswell, et al., 2003). These three approaches have its own strengths and weaknesses as Johnson & Onwuegbuzie (2004) point out on Table 3.1. It is the task of researchers to find out the most suitable research approach to use in their research. Mixed

methods are applied in this study since it is more powerful in examining the health and wellbeing of intermarried Filipino women in a new cultural environment.

Table 3-1: *Strength and weaknesses of the three approaches to research adapted from Johnson & Onwuegbuzie (2004, pp. 19-21)*

| Quantitative  | Qualitative   | Mixed methods  |
|---|---|--|
| <b>Strength</b>   |   |  |
| <b>1. Testing and validating already constructed theories about how (and to a lesser degree, why)</b>   | 1. The data are based on participants' own categories of meaning.   | 1. Words, pictures, and narratives can be used to add meaning to numbers.  |
| <b>2. Testing hypothesis that are constructed before the data are collected.</b>  | 2. It is useful for studying a limited number of cases in depth.  | 2. Numbers can be used to add precision to words, pictures and narratives.   |
| <b>3. Useful for obtaining data that allow quantitative precisions to be made.</b>  | 3. Provides individual case formation.  | 3. Can provide quantitative and qualitative research strengths.  |
| <b>4. The researcher may construct a situation that eliminates the confounding influence of many variables, allowing one to more credibly assess.</b> | 4. Can conduct cross-case information.  | 4. Researcher can generate and test a grounded theory.   |
| <b>5. Provides precise, quantitative, numerical data.</b>   | 5. Provides understanding and description of people's personal experiences of phenomenon (i.e., the "emic" or insider's viewpoint). | 5. Can answer a broader and more complete range of research questions because the researcher is not confined to a single method of approach. |
| <b>6. Data analysis is relatively less time consuming (using statistical software).</b>   | 6. Can describe in rich detail, phenomenon as they are situated and embedded in local contexts.                                     | 6. A researcher can use the strength of an additional method to overcome the weaknesses in another method by using both in research study.   |
| <b>7. The researcher results are relatively independent of the researcher.</b>  | 7. The researcher identifies contextual and setting factors as they relate the phenomenon of interest.                              | 7. Can provide stronger evidence for a conclusion through convergence and corroboration of findings.   |

| Quantitative  | Qualitative   | Mixed methods   |
|---|---|---|
|   | 8. The researcher can use the primarily qualitative method of “grounded theory” to generate inductively a tentative but explanatory theory.                           | 8. Can add insights and understanding that might be missed when only single method is used.   |
|   | 9. Can determine how participants interpret constructs (e.g., self-esteem, IQ).   | 9. Can be used to increase the generalisability of the results.   |
|   | 10. Data are usually collected in naturalistic settings in qualitative research.  | 10. Qualitative and quantitative research used together produce more complete knowledge necessary to inform theory and practice.  |
| <b>Weaknesses</b>   |   |   |
| <b>1. The researcher’s categories that are used may not reflect local constituencies’ understandings.</b>   | 1. Knowledge produce may not generalise to other people or other settings (i.e., findings may be unique to the relatively few people included in the research study). | 1. Can be difficult for a single researcher to carry out both qualitative and quantitative research, especially if two or more approaches are expected to be used concurrently, it may require a research team. |
| <b>2. The researcher’s theories that are used may not reflect local constituencies’ understandings</b>  | 2. It is difficult to make quantitative predictions.  | 2. Researcher has to learn about multiple methods and approaches and understand how to mix them.  |
| <b>3. The researcher may miss out on phenomenon occurring because of the focus on theory or hypothesis testing rather than the theory or hypothesis generation (called the confirmation).</b> | 3. It is more difficult to test hypotheses and theories.  | 3. Methodological purists’ content that one should always work within either a qualitative or quantitative paradigm.  |
| <b>4. Knowledge produced may be too abstract and general for direct application to specific local situations, contexts, and individuals.</b>  | 4. It may have lower credibility with some administrators and commissioners of programs.  | 4. More expensive.  |

| Quantitative | Qualitative   | Mixed methods  |
|--------------|---|--|
|              | 5. It generally takes more time to collect data when compared to quantitative research.           | 5. More time consuming.  |
|              | 6. Data analysis is often time consuming.   | 6. Some of the details of mixed research remain to be worked out fully by research methodologists (e.g., problem of paradigm mixing, how to quantitatively analyse quantitative data, how to interpret conflicting data. |
|              | 7. The results are more easily influenced by the researcher's personal biases and idiosyncrasies. |  |

This study employs mixed methods design. Most researchers have defined mixed methods in a way they use the design in their study. According to Creswell and Plano Clark (2007) mixed methods design is a research design with shared philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process (Creswell & Plano Clark, 2007). As a method, it focuses on collecting, analysing, and mixing both quantitative and qualitative data. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone. However, Creswell, et.al, in their study, has pointed out the “different issues of mixed methods design definitions” (p. 212) by different researchers in reference to “procedural discussion of its design” (Creswell, et al., 2003, p. 212). For example, Fielding and Fielding (1986) refers it as an interrelating qualitative and quantitative data. Morse (1991) described it as a methodological triangulation and Miles and Huberman (1994) uses multi-method designs, linking qualitative and quantitative data. But the central to all these terms is the idea of combining or integrating different methods. Thus, “to argue for mixed methods



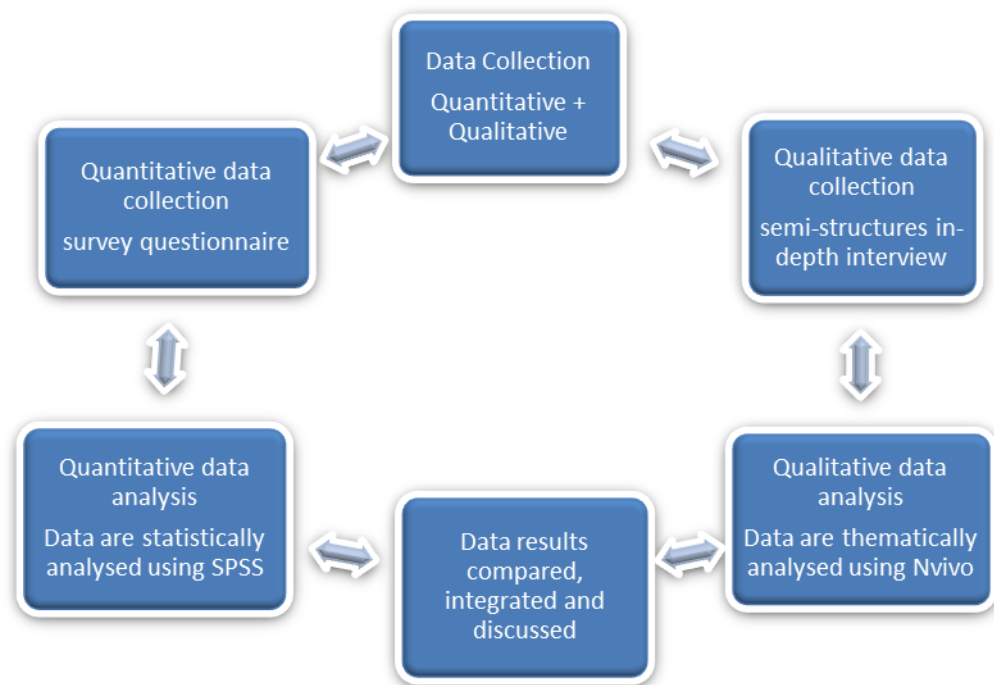
research as a specific research design requires not only an accepted term but also a common definition”(Creswell, et al., 2003, p. 212).

It is important to present and describe how researchers define mixed methods, in order to distinguish how the researcher in this study uses and define mixed methods design. Mixed methods research design is referred here as a combination of quantitative and qualitative methods in a single study. Mixed methods design has four major types namely: (1) Triangulation design; (2) embedded design; (3) explanatory design; and (4) exploratory design. In this study, concurrent triangulation mixed methods design is specifically applied. Concurrent triangulation design is the most common designs because it is familiar to most researchers which resulted to a well-validated and substantiated findings (Creswell, et al., 2003) . In this design, the researcher uses quantitative and qualitative methods in an attempt to confirm, cross-validate, and corroborate findings as well as integrate the findings of each methods (Creswell, et al., 2003). Furthermore, Creswell, et. al., (2003) has pointed out the number of limitations in this design that is:

*It requires a great effort and expertise to adequately study a phenomenon with two separate methods. It can also be difficult to compare the results of two analyses using data of different forms. In addition, it may be unclear to a researcher how to resolve the discrepancies that arise in the results.*  
(Creswell, et al., 2003, p. 229)

A limitation of this design is what makes the design worth using, not because of the researcher’s lack of knowledge about the design but testing the expertise and credibility of the researcher and the team. To note, every research methodology has its limitations.

The figure below is showing the flow of concurrent mixed method design employed in this study which is patterned after Hosler and Vesper (1993).



*Figure 3-1: The flow of mixed method designs used in this study, adapted from Hosler and Vesper (1993)*

The reasons for employing mixed methods design in this study are:

- Mixed methods research provides strength that offset the weaknesses of both quantitative and qualitative research (Creswell & Plano Clark, 2007).
- Mixed methods research provides more comprehensive evidence for studying a research problem than either quantitative or qualitative alone. Researchers use different tools of data collection available rather than being restricted to the types of data collection typically associated with qualitative research or quantitative research (Creswell & Plano Clark, 2007).

The tools used for data collection in this study are survey questionnaire (quantitative approach) and structured interview (qualitative approach).

Quantitative data were analysed using SPSS version 16 and NVivo version 8 was used for analysing qualitative data (The data collection and data analysis processes will be explained under each particular approach).

Both qualitative and quantitative data collection involve phases of sampling, permission, selecting types of data, selecting forms for recording data, and administering the data collection. At each phase, the approaches differ for the two forms of data collection. Therefore it is helpful to conceptualise the data collection procedures in this mixed methods research study as to either concurrent or consequential (Creswell & Plano Clark, 2007). In this study data are collected during the same timeframe but independently.

### **3.2.1. Quantitative approach**

Quantitative approach refers to a research paradigm designed to address questions that hypothesise relationship among variables that are measured frequently in numerical and objective ways (Newman, Ridenour, Newman, & DeMarco, 2003). This section discusses the data collection and measurement process, and data analysis of the quantitative research in this study.

#### **3.2.1.1. Participants selection process**

A calculated sample size of approximately 250 (95% Confidence Level) is sufficient for this study. About 250 intermarried Filipino women were invited to participate in the survey questionnaire. Intermarried Filipino women are the Filipino women married to Australian men, whether they were married in the Philippines or in Australia as long as they have been living in rural parts of Tasmania.

Their eventual participations were based on:

- Their willingness to participate in the study;
- That they have been living in rural parts of Tasmania;
- Their experiences as wives of Australian men; and
- Their experiences in the health and health care services in Tasmania.

To solicit their participation in this study, two main recruitment strategies were used:

- Contact through the Filipino Associations of Tasmania and the Migrant Resource Centre in Tasmania; and
- Contact via a snowball process that started from an initially small group of interested parties or participants and the momentum built up from there. For example, contact was made through a network of close friends who introduced others to the study.

### **3.2.1.2. Quantitative instrument: questionnaire**

A questionnaire was designed in this study to gather the quantitative data. It was used to collect two principal types of information that the participants were expected to provide facts and opinions. Facts are items of information about the backgrounds and personal information of the participants (i.e., their demographic background). Opinions are expression of attitudes, behaviour or preferences (Murray, 2003). Furthermore, this questionnaire was specifically designed to examine how the personal backgrounds of the intermarried Filipino women (independent variables) affected their views and attitudes on health and wellbeing in terms of health concept, access to health care services and acculturation strategies (dependent variables). It took approximately 15 minutes to answer the questionnaire.

Copies of the questionnaire together with reply paid envelopes were made available to the recruitment agencies. The questionnaire has three parts:

- Part 1: was about demographic background, which includes independent variables such as age, level of education, language ability, areas of living in the Philippines, income range, and the length of stay in rural Tasmania.
- Part 2: was about the views and attitudes of the participants towards health and wellbeing using a 5-point Likert scale. The questions are grouped under the following headings: health concept, access to health care services, issues in health care services, wellbeing, personal wellbeing, and general health and wellbeing.

- Part 3: consisted of open-ended questions that capture comments that have not been addressed in Parts 1 and 2. The Participants were invited to share their views which they think would be beneficial to the study.

Table 3-2: *Structure of the Questionnaire (full details in Appendix 1)*

|   |  |
|---|--|
| Part 1:<br><b>Participant's Personal Background</b>                   | Items 1 – 7 (Nominal data)<br>Age group?<br>Highest level of education?<br>Area in the Philippines they come from?<br>Years of living in Tasmania?<br>Employment status?<br>English competence? Combined household income?   |
| Part 2:<br><b>Health and Wellbeing</b>                                | Items 8 – 49 (Ordinal data)<br>Health concept and well-being (items 8 - 18)<br>Access to health care services in Australia (items 19 – 24)<br>Health care services for migrants (items 25-30)<br>Personal wellbeing in the acculturation process (items 31-44)<br>General health and wellbeing (items 45 – 49) |
| Part 3:<br><b>Open questions: any other information/idea/comments</b> |  |

In examining the views and attitudes of the intermarried Filipino women towards their health and wellbeing, a 5-point Likert scale was applied in the questionnaire (as explained below):

*Five-point Likert scale is a set of items, composed of approximately an equal number of favourable and unfavourable statements concerning the attitude object, is given to a group of subjects. They are asked to respond to each statement in terms of their own degree of agreement or disagreement. Typically, they are instructed to select one of five responses: strongly agree,*

*agree, undecided, disagree, or strongly disagree. The specific responses to the items are combined so that individuals with the most favourable attitudes will have the highest scores while individuals with the least favourable (or unfavourable) attitudes will have the lowest scores. While not all summated scales are created according to Likert's specific procedures, all such scales share the basic logic associated with Likert scaling. (McIver & Carmines, 1981, pp. 22-23)*

The questionnaire had been piloted prior to the actual data collection. The term "pilot study" (also called "feasibility" study) refers to a mini version of a full-scale study, and the specific pre-testing of a particular research instrument such as a questionnaire (van Teijlingen & Hundley, 2001). According to Bryman (2004), it is desirable to conduct a pilot study before administering a self-completion questionnaire to your sample. Bryman (2004) further explains that the desirability of piloting such instruments is to do with not solely trying to ensure the survey questions operate well but also ensuring that the research instrument as a whole functions well. The purpose in conducting a pilot study is based on Murphy's Law which states that, "anything that can go wrong, will go wrong. The reason to run a pilot study is to ensure that the things that do wrong, go wrong during the pilot study and will be treated before conducting the actual or full study" (Simon, 1999para. 11).

The aim of conducting a pilot study in this study is to determine whether:

- it is possible to investigate this subject or topic.
- many will accept or turn down the opportunity to participate in the study. Are the participants able to answer all the questions or will they fail to finish answering the questionnaire (Simon, 1999).
- it takes too long for a participant to answer the questionnaire or it takes too long for a participant to send back the questionnaire (Simon, 1999).
- the sampling frame and technique are effective.

- every question, every question sequence and every scale are well designed (Oppenheim, 1992).
- the question lay-out, the instructions given to the participants, the answer categories and even the question-numbering are appropriate in the study (Oppenheim, 1992).
- piloting can help the researchers with the wording of the questions and with procedural matters such as the design of the letter of introduction, the ordering of question sequences and the reduction of non-response rates.
- pilot work may be costly or it would actually save time and money in the end. As Oppenheim (1992) says, studies which have been inadequately piloted or not piloted at all will find that a great deal of effort has been wasted on unintelligible questions producing unquantifiable responses and uninterpretable results.
- it gives advance warning about where the main research project could fail, where research protocols may not be followed, or whether proposed methods or instruments are inappropriate or too complicated (van Teijlingen & Hundley, 2001). In the words of De Vaus (1993), “do not take the risk, pilot test first” (p. 54).

Piloting the questionnaire of this study was done exactly the same way as it was administered in the main study (van Teijlingen & Hundley, 2001) which was through the Filipino Community Association, the Migrant Resources Centre and through a snowball process. The questionnaire was piloted first to approximately 30 invited participants.

Pilot studies also have limitations and problems. As van Teijlingen and Hundley (2001) say:

*The common problem researchers faced in doing a pilot study is whether to include pilot study participants in the main study. The concern here is that these participants already been exposed to an intervention and, therefore,*

*may respond differently from those who have not previously experienced it. This may result positively as participants may become more adept at using a new tool or procedure. However it may also be negative with participants showing a decline in following a protocol because it is no longer novel. (para. 11)*

This problem arises in particular because as stated in the information sheet, the Filipino wives who were invited to participate in the study were those who have lived in Tasmania for not more than 15 years. Since not many Filipino women were new comers, their participation in the pilot study is highly appreciated for testing the questionnaire as the attitude and behaviour of the new comers may differ from those who have been here for quite a while. Due to the small number of Filipino women in rural Tasmania the participants involved in the pilot study were invited again to participate in the actual survey. Most of the participants involved in the pilot study were recruited via snow ball process. There were no complains and rejections from the participants.

### **3.2.1.3. Questionnaire data collection**

The data collection process of the questionnaire, together with the pilot study, took about 11 months. The first three months was spent on the pilot study of about 30 invited participants and 25 responded. After piloting the questionnaire, the data and the questionnaire were examined in preparation for the actual collection of data.

The questionnaire was administered using three strategies to increase the response rate:

- *Distribution survey:* With permission of the Filipino Community Associations and the Migrant Resources Centre, the questionnaires were made available at the reception areas of recruitment agencies. The participant completed the questionnaire on her own and returned the questionnaire by mail, drop box at the reception areas, or any other means preferred by the participant.



- *Administration in a public place:* In certain public meetings of the Filipino Community Associations and/or the Migrant Resources Centre, the researcher explained to the invited participants about the nature of the study. Then they were given an information sheet to read and keep. This strategy was used in order to get the maximum number of participants.

In order to solicit most responses from the invited participants, two strategies were carried out:

- Firstly, by sending a reminder letter via the recruitment agencies. The reminder informed the participants about the due date for returning the questionnaire.
- Secondly, following up with phone calls through the recruitment agencies. Following up questionnaires were resent to participants if the response rate was low.

#### **3.2.1.4. Questionnaire data analysis**

For the survey questionnaire, collected data were coded and analysed with the use of SPSS (Statistical Package for the Social Sciences) version 16 to examine the relationship between Filipino women's demographic background and their views on health and wellbeing in rural Tasmania and their access to health care services. The analysis results were presented in the form of frequencies or proportions. Median values were employed when continuous data were available. Inferential statistical techniques (e.g., Chi-Square, Regression tests) were employed where possible to determine the significance of the results.

#### **3.2.2. Qualitative approach**

Qualitative method was applied in this study to explore the perspective and meaning of life's experiences and to understand why people behave as they do such as their knowledge, attitudes, beliefs, fears. It also allows the subjects being studied to give much 'richer' answers to questions put to them by the researcher, and may give valuable insights which might have been missed by the quantitative method.

Qualitative method does not only provide valuable information to certain research questions in its own right but there is a strong case for using it to complement quantitative research methods. In this study, qualitative method is very important because it examines the health and wellbeing of intermarried Filipino women (Taunton, n.d.). Therefore, statistical data (quantitative) alone cannot fully explain the likely reason if they have an ill health or a good health.

### **3.2.2.1. Participants selection**

The participants are intermarried Filipino women who are also participants in the survey questionnaire. The selection processes used the same strategies for the survey questionnaire which have been discussed above. Fifteen participants were invited to participate in the face-to-face semi-structured interviews.

### **3.2.2.2. Qualitative instrument: semi-structured interview**

Semi-structured face-to-face interviews were used for the qualitative approach. Semi-structured interview allows researchers to develop an in-depth account of experiences and perceptions with individuals. By collecting and transcribing interview talks, the researcher can produce rich empirical data about the lives and perspectives of the individuals (Cousin, 2009). The interview questions are related to the research objectives of this study, which are made up mainly of open-ended and a few closed-ended questions. There were 11 key open-ended questions in the interview and each set of questions had two prompt questions to motivate the participants to offer more in-depth answers. As Rubin and Rubin point out, “prompt questions helped in managing conversation by regulating the length of answers and the degree of details, clarifying unclear sentences, filling in missing steps, and keeping the conversation on the topic questions” (Cousin, 2009, p. 86). The closed-ended questions in the interview are mainly demographic aspect of the participants which is not taken from the quantitative questionnaire (e.g., year of arrival in Australia, age gap with the husbands, religion). The interview took about an hour per participant. Phone interviews were also used upon the participants’ requests.

Interview is one of the common data collection tools in qualitative research. It is a very good way of accessing people's perception, meanings, definition of situation and construction of reality. It is also one of the most powerful ways we have in understanding others (Punch, 1998). As Jones (1985) argues:

*In order to understand other persons' construction of reality, we would do well to ask them... and to ask them in such a way that they can tell us in their terms (rather than those imposed rigidly and a priori by ourselves) and in depth with which addresses the rich context that is the substance of their meanings. (p. 46)*

According to Hancock (1998), semi-structured interview involves a number of open-ended questions based on the topic areas that the researcher wants to cover. The open-ended nature of the questions posed defines the topic under investigation but provides opportunities for both the interviewer and the interviewee to discuss some topics in more detail. Hancock (1998) further describes that if the interviewee has difficulty answering a question or provides only a brief response, the interviewer can use cues or prompts to encourage the interviewee to consider the question further. Thus this technique will help the researcher get the answer or the information needed for the study.

### **3.2.2.3. Interview data collection**

The interview data collection process took about four months. The semi-structured interviews were conducted to gather more detailed information from the participants. The data from the interviews were very important in complementing information obtained from the questionnaires. Before the interview, the participant was given an information sheet regarding the nature of the study and a consent form. Once the consent form was signed, an interview would be conducted.

The interviews were conducted at a place mutually convenient to the participants and the researcher. Phone interviews were used upon participants' requests. The questions raised in the interviews were mainly about issues on health and wellbeing, acculturation issues and strategies which are also reflected in the

literature review, access to health care services and the participant's experiences as migrants.

#### **3.2.2.4. Interview data analysis**

There are various types of analytical procedures within qualitative research. According to Grbich (1999), certain approaches have well-articulated (although considerably debated) processes attached to them, such as grounded theory, phenomenology, and content and discourse analysis. Other approaches vary depending on whether an "objective" (distant researcher) position is involved, or whether the researcher's submergence in the data or his/her subjective view is required. Qualitative data analysis explores themes, patterns, stories, narrative structure and language within research texts (e.g., interview transcripts, field notes, documents, visual data) in order to interpret meanings and to generate rich depictions of research settings (Grbich, 1999).

In this study, qualitative data were analysed through grounded theory analysis and thematic analysis with the aid of NVivo version 8. According to Znaniecki (1934),

*Grounded theory is an analytic inductive technique (going from observed instances to the development of a law or model of action in a rigorous manner), based in the interpretive tradition, with an emphasis on individual power, choice and construction of meaning. It includes a rigorous guide to data collection and analysis in the generation of substantive and formal theory.* (Grbich, 1999, p. 171)

However, thematic analysis is a process for encoding qualitative information. The encoding requires an explicit "code". This may be a list of themes: a complex model with themes, indicators, and qualifications that are casually related; or something in between these forms. A theme is a pattern found in the information that at minimum describes and organises possible observations or at the maximum interprets aspects of the phenomenon. A theme may be identified at the manifest level (underlying the phenomenon). The themes may be initially generated inductively from the raw information or generated deductively from theory and

prior research. In short, Thematic analysis is a search for themes that emerge as being the important description of the phenomena (Fereday & Muir-Cochrane, 2006). The process involves the identification of themes through careful reading and re-reading of data; or line by line coding; or word by word coding (Fereday & Muir-Cochrane, 2006; Rice & Ezzy, 1999; Thomas & Harden, 2008).

According to Punch (2005), the essential idea in discovering a grounded theory is to find a core category, at a high level of abstraction but grounded in data, which accounts for what is central in the data. In doing grounded theory analysis, three steps are followed: first, to find conceptual categories in the data, at a first level of abstraction; second, to find relationships between these categories; third, to conceptualise and account for these relationship at a higher level of abstraction (Punch, 2005). These three steps imply three general types of codes, such as: *substantive codes*, which are the initial conceptual categories in the data; *theoretical codes*, which connect these categories; and the *core code*, which is the higher-order conceptualisation of the theoretical coding, around which the theory is built. Thus the heart of grounded theory analysis is coding. Coding is the specific and concrete activity that starts the analysis. Codes are tags, names or labels, and coding is therefore the process of putting tags, names or labels against pieces of data. The pieces maybe individual words, a small or large chunks of data. The point of assigning labels is to attach meaning to the pieces of data, and these labels served a number of functions. They index the data, providing a basis for storage and retrieval. The labels also permit more advanced coding, which enables further summarising of the data by pulling together themes, and by identifying patterns (Punch, 2005).

The coding process in this study involved the following strategies suggested by Strauss and Corbin (Grbich, 1999, p. 175):

- Open coding – is a word-by-word, line-by-line analysis that occurs every time the data are collected. This process is designed to fracture the data and then group them conceptually, generalising concepts that emerge from it and fit within it.

- Axial coding – involves intensive analysis of one category that has been developed in open coding. It is used to develop connections between this category and its subcategories.
- Selective coding – is the process of validating the relationship between a core category and other categories. The core category can be identified by its centrality, frequent occurrence, good connections to other categories and implications for more general theory.

Since NVivo version 8 is used as a tool to analyse the qualitative data, the coding process explained above corresponds to the use of nodes in NVivo. Nodes are where the data, themes, ideas and categories are stored. There are three types of nodes:

- Free nodes – are “stand alone nodes” (open coding).
- Tree nodes – are categories, sub-categories, etc., organised in a hierarchical structure. The branches of each “tree” are a logical sort or filter of the category above (axial coding).
- Case nodes – can represent a person, institution or organisation and is a way of gathering together all the content that belongs to that entity (selective coding).

Due to the richness of data collected from the interviews and in an attempt to discuss the results of the data analysis without losing the true sense of the data from the fragmentation and decontextualisation process, narratives and meaning approach was used in presenting and explaining the data results. Narrative is used in order to make sure that the data analysis is holistically explained, as narrative research provides evidence in the form of real life stories. In the Filipino culture, narrative is a common way of expressing and sharing the meaning of life, particularly among women.

### **3.3. Reliability and validity issues**

Reliability and validity issues of research instrument and the data are the most common problem researcher's has encountered. The fundamental aspect in rationalising a mixed methods research design is that both single methodology approaches (qualitative only and quantitative only) has strengths and weaknesses. The combination of methodologies can emphasise on their relevant strengths. According to Nau (1995) the role of the researcher was to make sure that "the blending of qualitative and quantitative methods of research can produce a final product which can highlight the significant contributions of both" (para. 4) where qualitative data can support and clarify the meaning of quantitative research findings. The goal of using mixed methods in this research is not to replace either quantitative or qualitative research. Rather to utilise the strengths of two or more approaches by combining them in one study, and by attempting to minimise the weaknesses of approaches in mixed designs (Onwuegbuzie & Johnson, 2006). Thus this helps the increase of validity and reliability of research instruments.

Since this study employed a concurrent mixed method design where the quantitative and qualitative data where concurrently conducted. The testing of reliability and validity of each research instrument used was also checked separately. However, data findings from both quantitative and qualitative data were integrated in the discussion and presentation chapter to present the validity of the results.

#### **3.3.1. Reliability in quantitative approach**

Reliability is a term commonly used in everyday life. According to Longman and Kumar (1996) if a person is reliable, it means he/she is dependable, consistent, predictable, and honest. In relation to a research instrument, the concept of reliability has a similar meaning: if a research tool is consistent and stable, and hence, predictable and accurate, it is said to be reliable. The greater the degree the consistency and stability in an instrument, the greater is its reliability (Longman & Kumar, 1996). There are factors affecting the reliability of an instrument such as:

- The wording of questions – a slight ambiguity in the wording of questions or statements can affect the reliability of a research instrument. Hence, the questionnaire used in this study was revised three times prior to pilot studies and twice before conducting the actual survey. The questionnaire was carefully checked by the supervisors and external experts.
- The physical setting – in the case when an instrument is being used, any change in the physical setting at the time may affect the responses given by a participant, which may affect reliability. The plot of the study is in rural areas. The questionnaires were sent out via Filipino community associations.
- The participant's mood – a change in a participant's mood when responding to the questions in the questionnaire can change and may affect the reliability of the instrument.
- The regression effect of an instrument – when a research instrument is used to measure attitudes towards an issue, some participants after having expressed their opinion, may feel that they have been either too negative or too positive towards the issue. The second time they may express their opinion differently, affecting reliability (Kumar and Longman, 1996).

Other factors that was considered in making the questionnaire in order to be valid were adopted from Chisholm, Dombal and Giles (1985) such as: (a) to be acceptable to the population under study; (b) to be easily completed; (c) to be consistent-that is, to elicit responses similar to those gained in a conventional doctor-patient interview; (d) to be reproducible when administered on two separate occasions; and (e) to be of value or use when complete.

Reliability is an important measurement of data because it is where the researcher can see the consistency of measurement. The two methods of testing the reliability of a questionnaire are: Cronbach's Alpha Coefficient and Split-Half Method. Cronbach's Alpha Coefficient measures the relationship between the observed scores in a group of persons' responses to a set of questions (items) and the true scores, i.e. the scores that would be obtained if the scores were not contaminated



with noise, e.g. fortuitous guessing in the absence of knowledge of the true response. However the Split-Half Method divides the test into two halves and sees how far the scores from each half correlate which indicates the internal consistency of the test (Foster, 1998).

To test the reliability of the research instrument used in this study, Cronbach's Alpha Coefficient was conducted and SPSS version 16 was applied to assess the reliability. Since the research instrument (questionnaire) has multiple items, the main question for the reliability test is whether the items in the questionnaire are consistent with each other. The reasons for using Cronbach's Alpha Coefficient instead of the Split-Half Method are:

- Cronbach's alpha estimates the proportion of variance in the test scores that can be attributed to true score variance. It is also used to estimate the proportion of variance that is systematic or consistent in a set of test scores. The variance can range from 0 (if no variance is consistent) to 1.00 (if all variance is consistent) with all values between 0.0 and 1.00 also being possible. For example, if the Cronbach's alpha for a set of scores turns out to be .90, one can interpret that as meaning that the test is 90% reliable, and by extension that it is 10% unreliable ( $100\% - 90\% = 10\%$ ) (Brown, 2002).
- Cronbach's alpha determines the internal consistency or average correlation of items in a survey instrument to gauge its reliability. Hence the questionnaire had been piloted and checked before the actual survey was conducted.

Burns and Burns (2008) has explained the methods of estimating reliability as follows:

*The methods of estimating reliability take into account both stability and equivalence will tend to give lower coefficients than the other methods because all major types of error variance are included. The Kuder-Richardson and Cronbach alpha methods will tend to yield lower coefficients than the split halves method because the former reflects test homogeneity, as*

*reflected in all inter-item relationships, rather than merely the consistency of two scores from the halves of a subdivided assessment. With any method involving two assessment occasions, the longer the interval of time between two occasions, the lower the coefficient will tend to be. (p. 422)*

When the questionnaire in this study was piloted the 42 item scale were run in SPSS to test its reliability and the Cronbach alpha is .877. This result is acceptable as the minimum alpha is .7.

### **3.3.2. Validity**

The concept of validity refers to quality and can be applied to any aspect of the research process. In respect to measurement procedures, it relates to whether a research instrument is measuring what is set out to measure. According to Kumar and Longman (1996), in social sciences there are two approaches to establishing the validity of a research instrument, namely: logic and statistical evidence. Kumar and Longman (1996), pointed out that:

*Establishing validity through logic implies justification of each question in relation to the objectives of the study, whereas the statistical procedures provide hard evidence by way of calculating the coefficient of correlations between the questions and outcome variables. Establishing the logical link between the questions and the objectives is both simple and difficult. It is simple in a sense that a researcher finds it easy to see a link for himself/herself, and difficult because his/her justification may lack the backing of the experts and the statistical evidence to convince others (p. 179).*

Kumar and Longman (1996), further explain that establishing a logical link between questions and objectives is easier when the questions relate to tangible matters. Therefore in this study the validity issues were addressed through a careful construction of the research instrument (questionnaire); data results were carefully checked using validation strategies like member checking, peer review, and consultation of the expert.

Ways in which questionnaire was validated:

- Pilot study was carried out to validate the 50-item questionnaire (8 items categorical and 42 items scale). Twenty-five Filipino women were willingly participated in the pilot test. The wording of questions, the physical setting, the participant's and the regression effect of an instrument were all assessed. The questionnaire disclosed similar results to those data from the actual survey. Only two participants' questioned item 8 and were revised to be properly understood before the questionnaire was sent out for the actual data collection. It is concluded that the pilot study helps validate the questionnaire by identifying unreliable questions.
- Piloted questionnaire were also analysed to find out its validity and to elicit invalid questions.

Valid and reliable assessment of research instrument facilitates a truthful explanation of data analysis results.

### **3.3.3. Reliability and validity in qualitative approach**

Like quantitative research, qualitative research is evaluated in terms of the reliability and validity of its instrument (Kirk & Miller, 1986). However, the instrument is validated differently. Reliability is defined as a measure to which the findings are independent of accidental circumstances of the research, and validity is the measure to which the findings are interpreted and explained in a precise manner (Kirk & Miller, 1986).

Qualitative researchers consider validity issues throughout the investigation process specifically from the planning stage to the final stage in order to come up with valid results. According to Whitemore, Chase and Mandle (2001), "findings subsequently need to be presented with an explicit articulation of the validity criteria of emphasis and the specific techniques employed, so that consumers of research can critique findings in a meaningful way" (p. 533). Lincoln and Guba (1985) also complemented that in qualitative research it is important to focus on validity to determine whether

the report provided by the researcher and the participants is accurate, can be trusted, and is credible. However, Creswell and Plano Clark explained that validity comes from the analysis of the researcher and from materials and evidences gathered while visiting and interacting the participants and external reviewers (Creswell & Plano Clark, 2007). Grbich (1999) however, has pointed out that validity in qualitative research lies in the reader being convinced that the researcher has the knowledge to access and accurately represent the social world under study. Thus in this study, the data collected from the interview were carefully analysed (which has been discussed above) and coded using the actual words of the participants. Member checking approach was also used in which the data summaries and findings were carefully checked by the primary and co-supervisors of the researcher. The data results were explained and presented using narrative and meaning approach to make sure all the emerging themes from the data analysis were clearly explained and conveyed to the readers.

Maxwell's (1992), five types of validity were also considered in this study to assist in validation of research instrument (interview questions):

1. Descriptive validity – factual accuracy of the account as documented by the researcher. During the collection of data (interview process) the data were recorded carefully and then transmitted to NVivo 8. As explained in the data analysis process the raw data was encoded word by word.
2. Interpretive validity – the extent to which an interpretation of the account represents an understanding of the perspective of the underlying group and the meanings attached to the members' words and actions. Data interpretations were done at the end of the analysis since the qualitative data was analysed using grounded theory and thematic analysis.
3. Theoretical validity – the degree to which a theoretical explanation developed from research findings is consistent with the data.

4. Evaluative validity – the extent to which an evaluation framework can be applied to the objects of study, as opposed to a descriptive, interpretive, or explanatory one; and
5. Generalisability – the extent to which a researcher can generalize the account of a particular situation, context, or population to other individuals, times, settings, or context (Onwuegbuzie & Johnson, 2006).

Maxwell (1992) pointed out “Validity is not an inherent property of a particular method, but pertains to the data, accounts, or conclusions reached by using that method in a particular context for a particular purpose” (p. 284). Methodology become an instruments to garner evidence supportive of validity (Whittemore, et al., 2001). However, adherence to methodology is not an assurance of validity and in fact may impede the development of exceptional qualitative research (Sandelowski, 1993; Whittemore, et al., 2001).

#### **3.3.4. Importance of reliability and validity in mixed method research design**

Based on the fundamental principle of mixed method research, this method involves the combination of quantitative and qualitative methods, techniques, procedures and concepts that have complementary strengths and overlapping weaknesses (Onwuegbuzie & Johnson, 2006). This principle is meant to be viewed broadly; not only limited to triangulation or corroboration. It also gives emphasis on the complementary strengths of quantitative and qualitative research. That is the reason why this method is applied in this study. Complementary strengths are meant to include all the strengths of qualitative and quantitative research. According to Onwuegbuzie and Johnson (2006), “by complementary strengths we are implying a putting together of different approaches, methods, and strategies in multiple creative ways”(p. 52). Therefore, using this method the researcher must fully understand the approaches and techniques of this method (specifically quantitative and quantitative methods).

As explained earlier, concurrent mixed methods design is specifically applied in this study. The following conditions were maintained:

- both the quantitative and qualitative data are collected separately at approximately the same point in time;
- neither the quantitative nor qualitative data analysis build on the other during the data analysis stage;
- the results from each type of analysis are not consolidated at the data interpretation stage, until both sets of data have been collected and analysed separately; and
- after collection and interpretation of data from the qualitative and quantitative components, a meta-inference is drawn which integrates the inferences made from the separate quantitative and qualitative data findings (Onwuegbuzie & Johnson, 2006).

Due to the complexity involved in mixed methods design (combining quantitative and qualitative methods) either using concurrent, sequential, parallel design, etc. the issue of integration has evolved. Therefore, it is important to look in and address the issue.

In this study, figure 3.1 has shown the flow of the study in which it was clearly emphasised that the data from both approaches were concurrently collected and was analysed separately. Data was only integrated during the final discussion stage which means both data from both approaches has been analysed. Therefore, in regards with the issue of integration of findings it was not much of a problem, because the methodology was carefully planned and studied prior to the conduction of research. Nonetheless, Onwuegbuzie and Johnson (2006) has pointed out Greene et.al.'s (Greene, Caracelli, & Graham, 1989) five general purposes for mixed methodological research which likely answers the integration issue such as:

1. triangulation (i.e., seeking convergence and corroboration of findings from different methods that study the same phenomenon);
2. complementarity (i.e., seeking elaboration, illustration, enhancement, and clarification of the findings from one method with results from the other method);
3. development (i.e., using the findings from one method to help inform the other method);
4. initiation (i.e., discovering paradoxes and contradictions that lead to a re-framing of the research question); and
5. expansion (i.e., seeking to expand the breadth and range of inquiry by using different methods for different inquiry components).

Mixed methods design could be very critical depending on how the researcher's views and knowledge about the method. The success of using mixed method design rely mainly on the researcher and her teams capabilities particularly in terms of applying the instruments and procedures of the methods. The blending, combination and mixing depend on the way of seeing. Therefore, it is best to emphasised that the way mixed methods design is used in this study is based on the researcher's understanding of the method.

### **3.4. Ethical issues**

Being ethical means adhering to the code of conduct that has been evolved over the years for an acceptable professional practice. Ethics is the science of morality and those who engage in it determine the values for the regulation of human behaviour (Homan, 1991). For most professions, ethical codes in research are an integral part of their overall ethics, though some research bodies have developed their own codes. According to Kumar (1996), in research any dilemma stemmed from a moral quandary is a basis of ethical conduct. Since this research involved human beings, ethical issues have been given importance. According to Spradley (1980), the researcher has an obligation to respect the rights, needs, values and desires of the

participants. This study involved a minimal risk to all the participants, therefore a minimal risk ethics application was submitted and approved by the Human Research Ethics Committee (Tasmania). Minimum risk means that the extent of harm or discomfort in the research is not greater than those ordinarily encountered in daily life (Longman & Kumar, 1996). In order to make the participants more comfortable in their participation in this research, each of them was given an information sheet, both for the questionnaire and the semi-structured interview as well as a consent form beforehand. This made sure that each participant was well-informed about her involvement and the benefits. Bailey (Longman & Kumar, 1996) states that in every discipline it is considered unethical to collect information without the knowledge of the participants, their informed willingness and express consent. Informed consent implies that the participants are made adequately aware of the type of information the researchers want from them, why the information is being sought, what purpose it will be put to, how they are expected to participate in the study, and how it will directly affect them (Longman & Kumar, 1996). The essence of informed consent is that the participants in the research should be allowed to agree or refuse to participate in the light of comprehensive information concerning the nature and the purpose of the research (Homan, 1991). Hence, it is important that the consent should also be voluntary and without pressure of any kind (Longman & Kumar, 1996). The central ethical issues in research are likely to revolve around potential invasions of privacy (Kimmel, 1996). Privacy is viewed by Westin (1968) as the claim of individuals, groups, or institutions to determine for themselves when, how, and to what extent information about them is communicated to others. While Ruebhausen and Brim (1966) define privacy as the freedom of individuals to pick and choose for themselves the time and circumstances under which, and most importantly, the extent to which, their attitudes, beliefs, behaviour and opinions are to be shared with or withheld from others.

Privacy is very important for the participants because “certain information is likely to be more sensitive and pose greater risks to participants than other information” (Kimmel, 1996, p. 132). For example, in American society, sensitive topics such as



those involving birth control practices, income level, drinking and driving, cheating on income tax, child and spousal abuse can be expected to raise privacy concerns (Kimmel, 1996). Other important ethical issues are confidentiality and anonymity. According to Beach (1996), confidentiality is perhaps the most sensitive aspect of a research process from the perspective of the rights and welfare of the participants. It is very important for every participant to have assurance of confidentiality as Boruch found that respondents are much more likely to yield sensitive information if confidentiality is offered, understood and believed (Reynolds, 1979; Turner, 1982).

All the ethical issues in these study – privacy, confidentiality and anonymity – were clearly explained in the information sheet and consent form for the participants (Appendix 1). Each participant was given a copy of the information sheet for them to keep for future reference.

### **3.5. Research limitation**

According to the 2006 census (2006), there were 770 Filipino female in Tasmania. Invitations were sent to 250 of these women to participate in the study (questionnaire and interview) of which 145 willingly participated. The number of participants posed a limitation to the study. As discussed in the literature review (discourses of the Filipino women), Filipino women by nature are shy and very private. The longer a Filipino woman lives in a rural area, the more reserved they are. Since this study is about Filipino women in rural Tasmania, there is a good reason why these Filipina were not responding. The researcher herself is a Filipina and she understands why not many have responded to the invitation. Another reason as to why the target sample size was not achieved is because the researcher herself does not have a personal contact with the invited participants. As mentioned earlier, the participants were recruited via Filipino community agencies. Once the questionnaires were distributed by the agencies, it is then beyond the researcher's control. Despite this limitation, the researcher is confident that she can provide reliable and valid results from the data gathered from the questionnaires

and semi-structured interviews. Having 58 percent response rate is more than enough to prove reasonable results.

### **3.6. Conclusion**

This chapter describes the procedures of how the study was carried out. It begins with describing the research design which is a mixed method, a combination of quantitative and qualitative approach. For the quantitative approach, a questionnaire was used as a research instrument. The questionnaire was designed to examine how the personal backgrounds of the intermarried Filipino women (independent variables) affect their views and attitudes on health and wellbeing in terms of health concept, access to health care services and acculturation strategies (dependent variables). However to get more in-depth information from the intermarried Filipino women, semi-structured interviews were used for collecting the qualitative data. The data collection was carried out concurrently while data analysis of different research methods was conducted separately since two separate computer software programs were applied. SPSS version 16 was used in analysing quantitative data and NVivo version 8 was used for analysing qualitative data. Other important issues discussed in this chapter are the reliability and validity issues as well as ethical issues. These issues are pivotal, because if the data are reliable and valid, the research is successful. This study dealt with human beings, therefore ethical issues were raised. Prior to the data collection process, ethic approval was sought. Once the ethic application was approved, data collection begun.

Mixed methods design suits this study best because quantitative and qualitative approaches complement each other. In studying health and wellbeing, it is best to provide statistical data as well as a rich set of data from in-depth interviews.

# **Chapter 4 – Quantitative data analysis**

## **4.1. Introduction**

This chapter presents the results of the quantitative analysis based on the data collected from the survey questionnaire. It contains statistical information about the views and attitudes of the intermarried Filipino women surveyed about their health and wellbeing. The data results that are presented in this chapter will particularly answer research questions 2 and 3 which examine the views of intermarried Filipino women about their health concept and health care in rural and regional Tasmania and the problems facing intermarried Filipino women in accessing health care in rural and regional Tasmania.

Quantitative data analysis is important in this research because it contains the statistical results of the data collected alongside the rich data gathered from the interviews. It provides a different perspective that complements the qualitative data analysis. Descriptive statistics were used first to describe the data which include percentage, frequency distribution, and cross tabulation to describe if the collected data were appropriate. Inferential statistics were also applied where possible to determine significance of the results. Chi-square tests of independence were carried out to make inferences about the factors that are important to the views and attitudes of the participants. Given the limited scope of this research, the statistical analysis has given importance to variables that were identified to be most influential to intermarried Filipino women participants' health and wellbeing and their access to health care services in rural Tasmania.

This chapter first presents a brief description of the survey administration process. Then, results collected from the data, such as: (i) demographic profiles of the participants; (ii) the participants' responses with regard to their views about health, health concept; access to health care services and general aspects of health and wellbeing will be identified. Chi-square tests were performed to analyse the

relationships between the participants' demographic background (i.e., age, level of education, and length of stay in Tasmania, area of location of residence in the Philippines, employment status, English language proficiency and combined household income) and their views about health and wellbeing as well as their access to health care services. Significance was taken as  $p\text{-value} \leq 0.05$ .

## **4.2. Survey response rate**

A total of 250 questionnaires were sent to two recruitment agencies, namely: Filipino Association of Tasmania and Migrant Resource Centre. Snowball sampling was also used to solicit third party recruitment. Three Filipino Associations were mainly involved in this research (Filipino-Australian Performing Group of Launceston, Philippine Australian Friendship of Launceston and Bayanihan Club from northwest Tasmania). A total of 145 questionnaires were returned with a response rate of 58 percent.

## **4.3. Profiles of the participants**

As discussed in Chapter 3 (Methodology chapter) intermarried Filipino women in rural Tasmania were the targets in this research. The participants' profiles discussed in this section are treated as the independent variables (i.e., age, level of education, length of stay in Tasmania, location of residence in the Philippines, English language proficiency, type of work and combined household income).

### **4.3.1. Age group**

Figure 4-1 shows the distribution of the participants by age group. Majority of the participants were in the 25-44 years of age group (46.9%); to be followed by the 45-54 of years of age (37.2%). Only 8.3% of the participants were in the 55-64 years of age group, while 4.1% were in the 65 years and over age group. A mere 3.4% of the participants were in the 24 years and under age group.

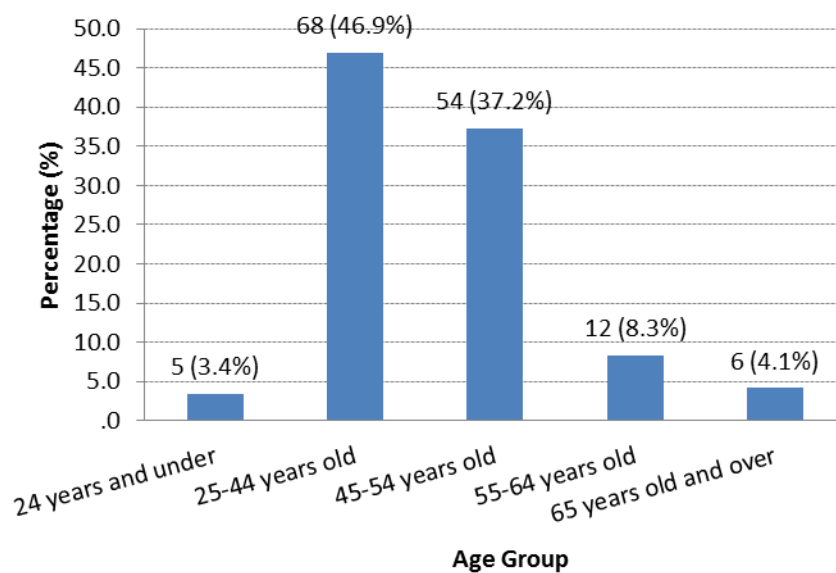


Figure 4-1: Distribution of participants by age group, n=145.

#### 4.3.2. Educational level

The educational level of the participants is presented in Figure 4-2. More than half of the intermarried Filipino women participants completed tertiary/university degrees (51.7%). About one-third attended a vocational study (29.7%). Only 15.2% participants finished high school and 2.8% of them finished primary education. Some of them (0.7%) have other qualification such as post-graduate studies.

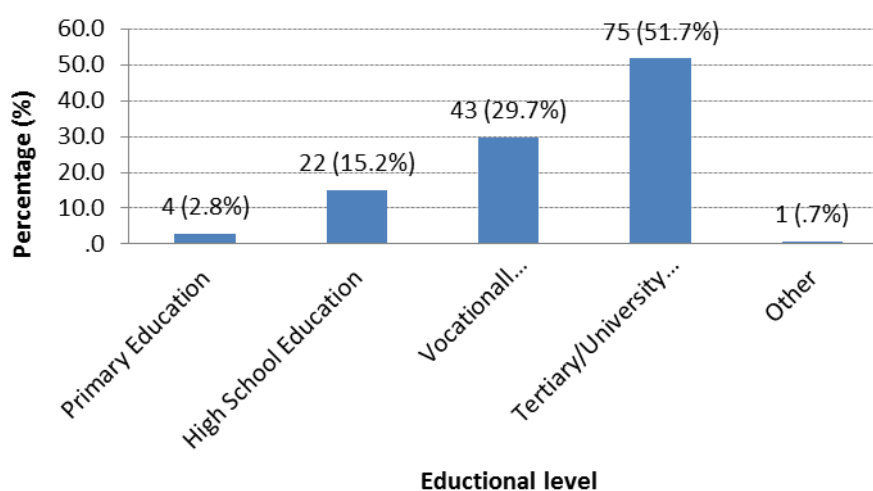
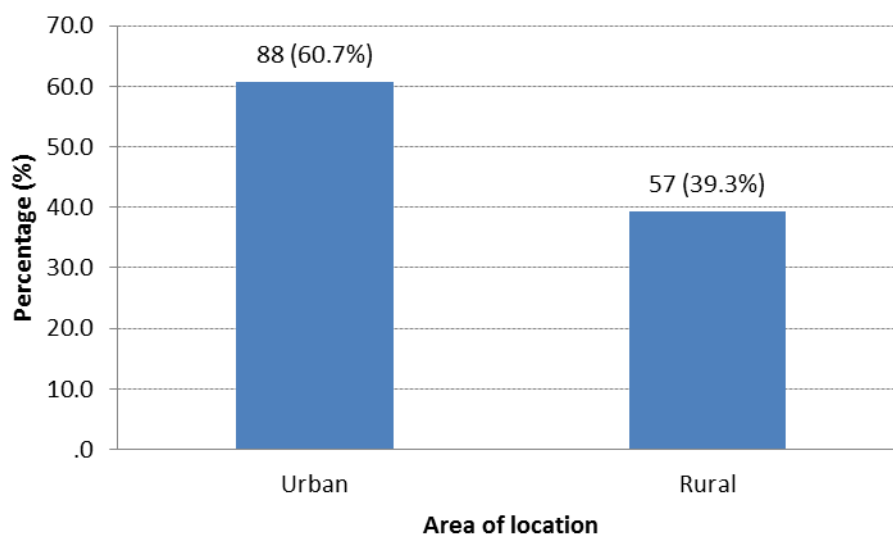


Figure 4-2: Distribution of participants by educational level, n=145.

### 4.3.3. Location of residence

As illustrated in Figure 4-3, 60.7% of the intermarried Filipino women participants came from the urban areas in the Philippines while 39.3% from the rural areas.



*Figure 4-3: Distribution of participants by location of residence in the Philippines, n=145.*

### 4.3.4. Length of stay in Tasmania

Figure 4-4 describes the length of stay of the participants in Tasmania. Most of the intermarried Filipino women participants (47.6%) have lived in Tasmania for over 10 years while 26.2% of the participants have been in Tasmania for 5 to 10 years. Nearly 16% of the participants have settled in Tasmania for 2 to 5 years and only 10.3% have resided in Tasmania for less than 2 years.

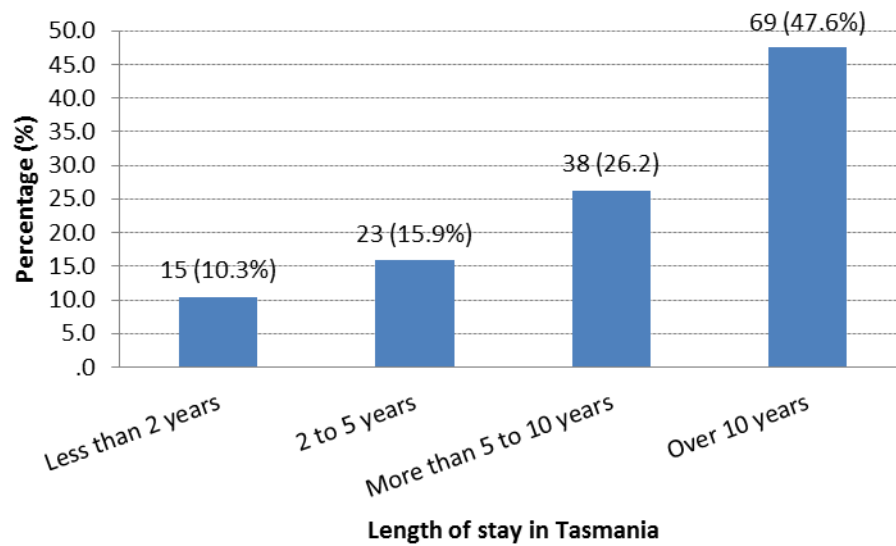


Figure 4-4: Distribution of participants by length of stay in Tasmania, n=145.

#### 4.3.5. Employment status

Among the 145 participants, 41.7% were not working while 22.2 % worked full-time, 18.1% engaged in part-time work and an equal percentage (18.1%) in casual work.

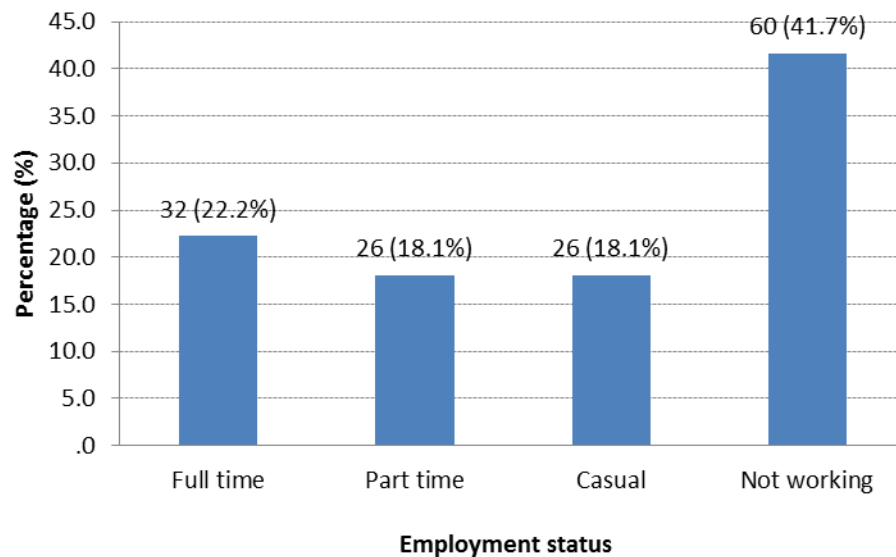


Figure 4-5: Distribution of participants by employment status, n=145.

#### 4.3.6. English language proficiency

As shown in Figure 4-6, 66.9% of the intermarried Filipino women participants indicated they could speak “good English” while 17.9% claimed to be excellent in English; 13.8 % of them reported “just fine” and 0.7% indicated that they had poor English language ability and another 0.7% very poor English language ability.

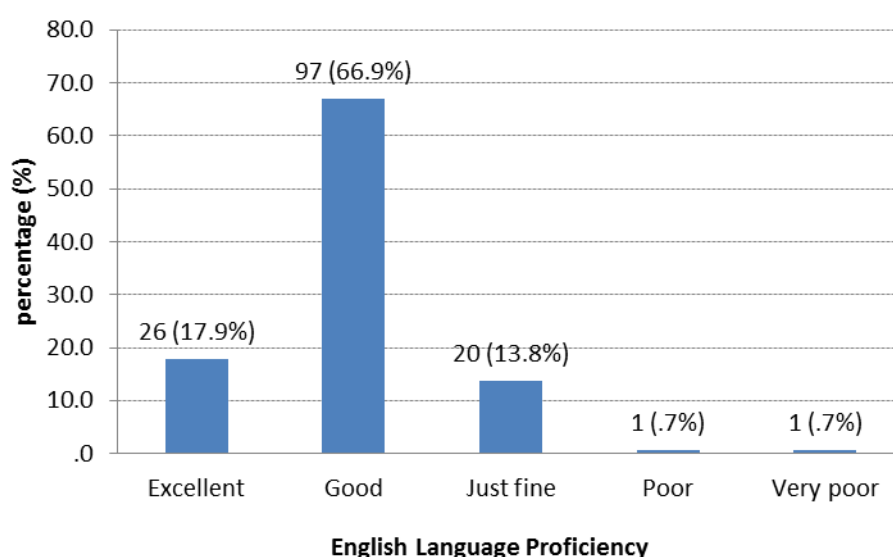


Figure 4-6: Distribution of the participants by English language proficiency, n=145.

#### 4.3.7. Combined household income

In regard to household income, nearly 40% of the intermarried Filipino women participants had a combined annual income between \$20,001 and \$40,000; while 29.4% of them had an income of \$40,001-\$60,000. The proportion of participants with a household income under \$20,000 is 15.4%. Only 8.8% of them fell in the range of \$60,001-\$80,000 and 2.2% had a combined income of more than \$100,000.



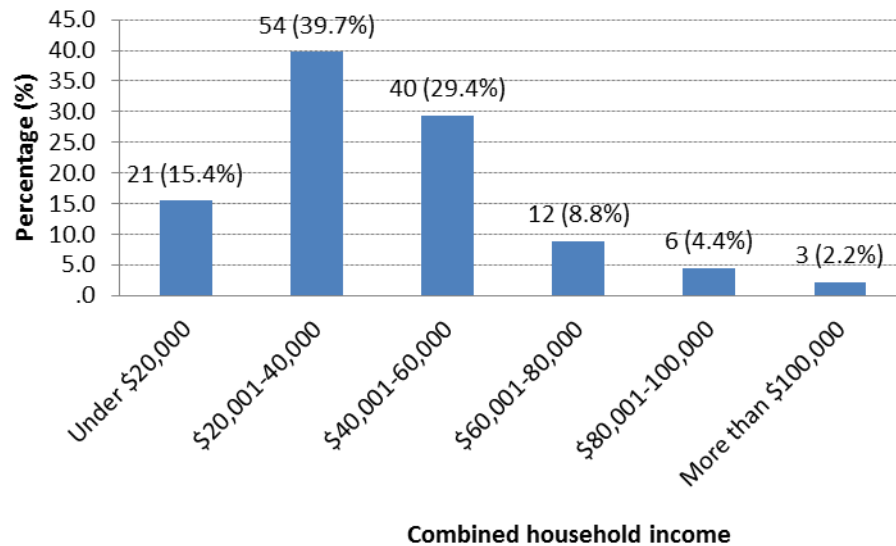


Figure 4-7: Distribution of the participants by combined household income, n=145.

## 4.4. Health and wellbeing

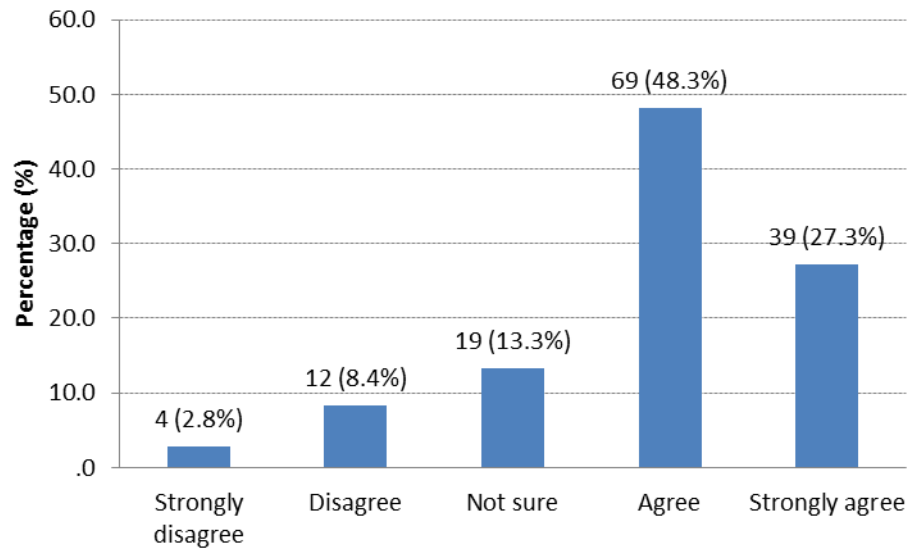
The main aim of the survey is to examine the general health and wellbeing of the intermarried Filipino women in rural Tasmania. The questionnaire was divided into the following themes: health concept, access to health care services, issues relating to health care services, personal wellbeing and general health and wellbeing.

Responses of the participants were analysed under these themes.

### 4.4.1. Health concept

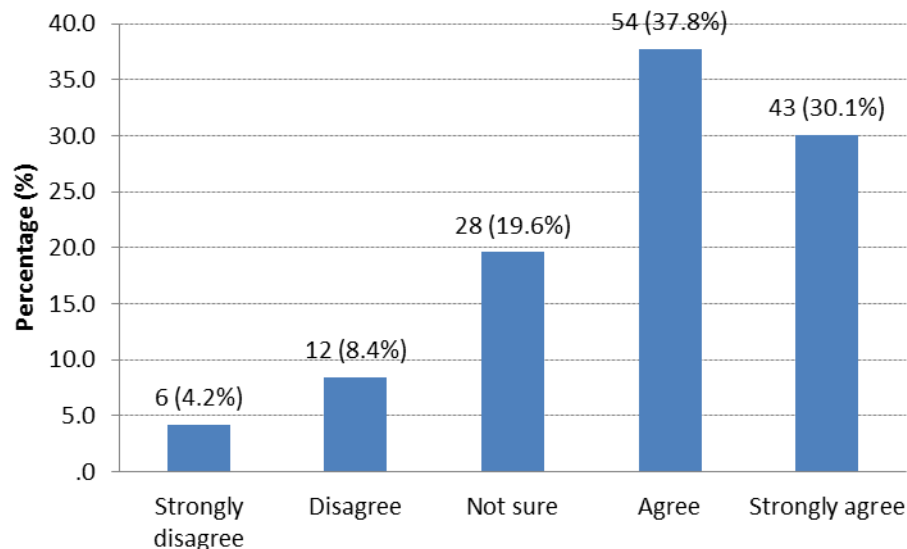
Figures 4-8 – 4-17 cover the views and attitudes of the participants towards health (as shown below).

Figure 4-8 shows the influence of the participants' traditional beliefs and views when they look after their own health. When responding to the statement "I still hold traditional Filipino beliefs and views in looking after my health", almost half of the participants (48.3%) answered "Agree" and 27.3% responded "Strongly Agree". Only 2.8% of the participants indicated "Strongly Disagree" with the statement.



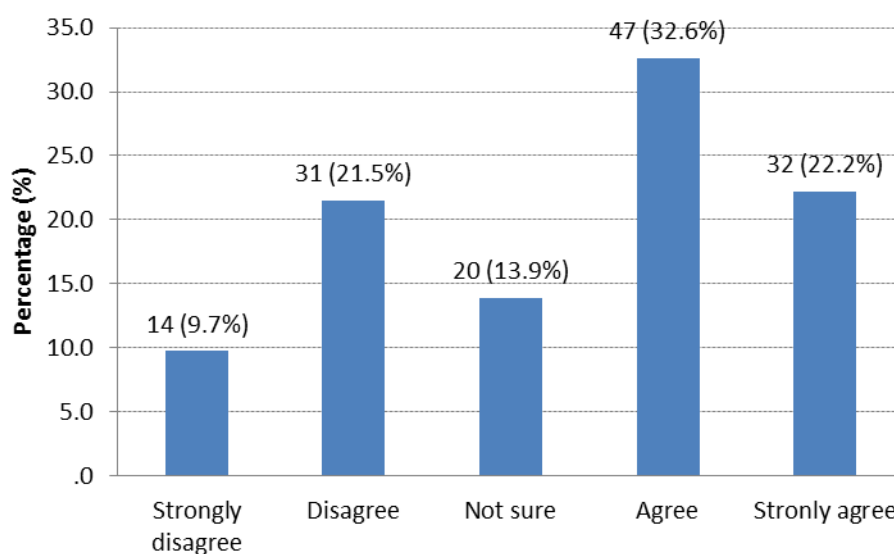
*Figure 4-8: Participants' responses to Q9 - "I still hold traditional Filipino beliefs and views in looking after my health", n=145.*

As shown in Figure 4-9, 37.8% of the participants agree and 30.1% strongly agree with the view that they need to know more to build a healthy lifestyle in Tasmania. Nearly 20% of the participants were not sure if they needed more information while 4.2% of them strongly disagree with the statement.



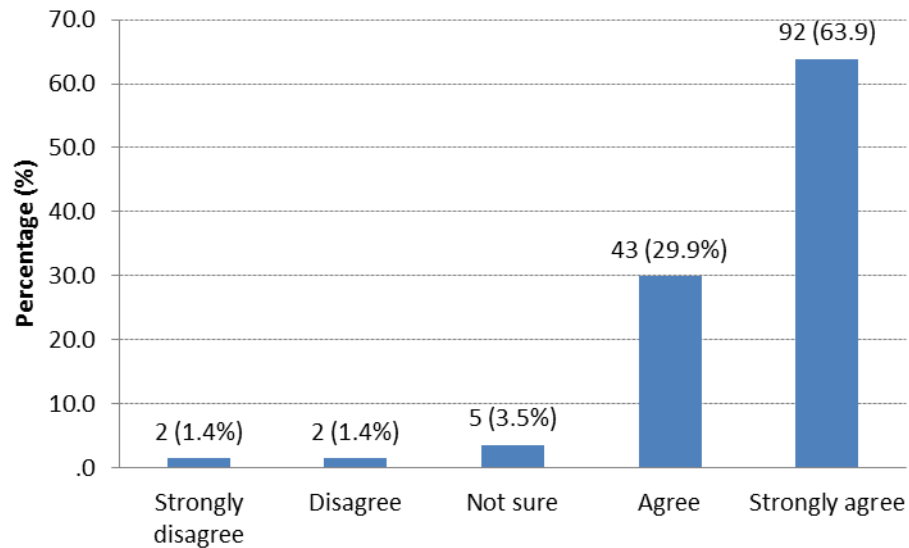
*Figure 4-9: Participants' responses to Q10 - "I need to know more about building a healthy lifestyle."*

Responses to the statement “the changes in weather conditions affect the health conditions of the participants” are presented in Figure 4-10. Some 32% of them agreed and 22.2% strongly agreed with this statement. Only 21.5% of the participants disagreed and 9.7% strongly disagreed.



*Figure 4-10: Participants’ responses to Q11- “The change in weather conditions affect my health”, n=145.*

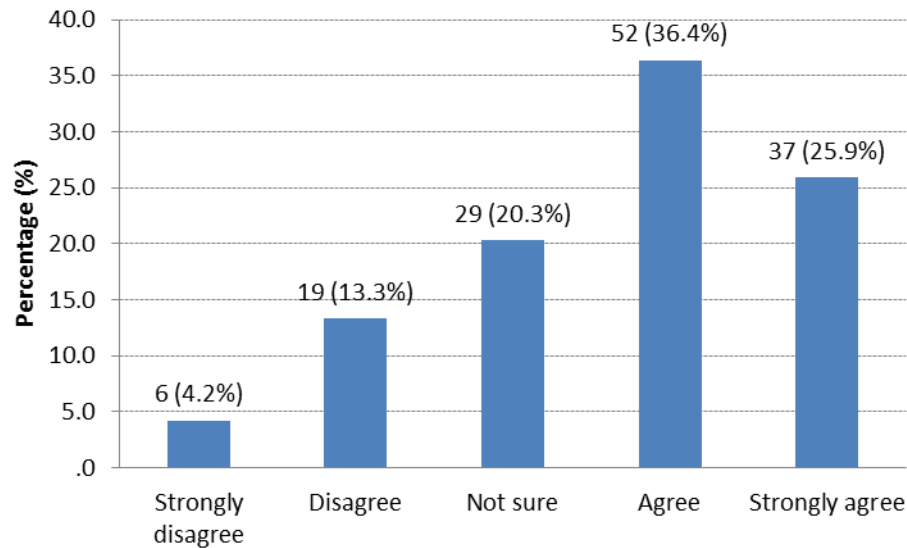
An overwhelming 93.8% of the participants asserted the importance of proper hygiene to their health while only 2.8% of them did not believe that proper hygiene is important to their health, as shown in Figure 4-11.



*Figure 4-11: Participants' responses to Q12 - "Proper hygiene is a vital aspect of my health", n=145.*

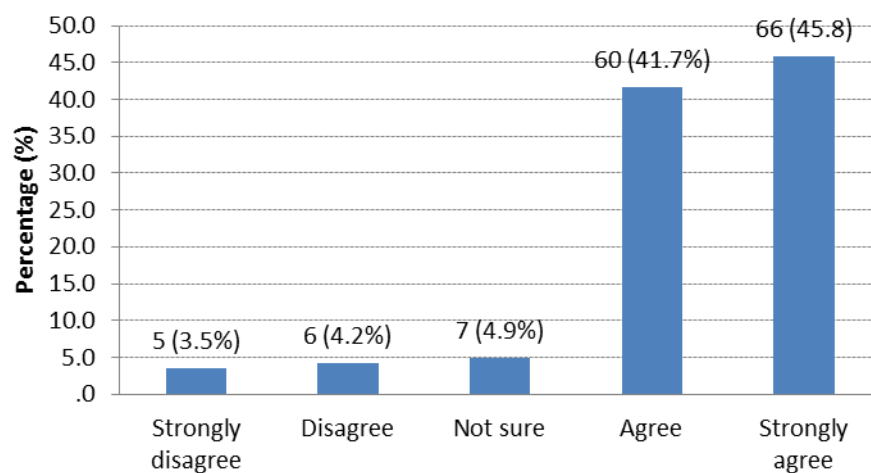
Figure 4-12 summarises the participants' perception of the importance of religion or faith in affecting their health. Filipino women in general are religious.

Approximately 36.4 % of the participants agree and 25.9 % strongly agree that their religion and faith have an important aspect in helping them maintain a good health. However, 20.3% of the participants were not sure about this. About 13.3% disagree and 4.2% strongly disagree that religion or faith has any effect on their health.



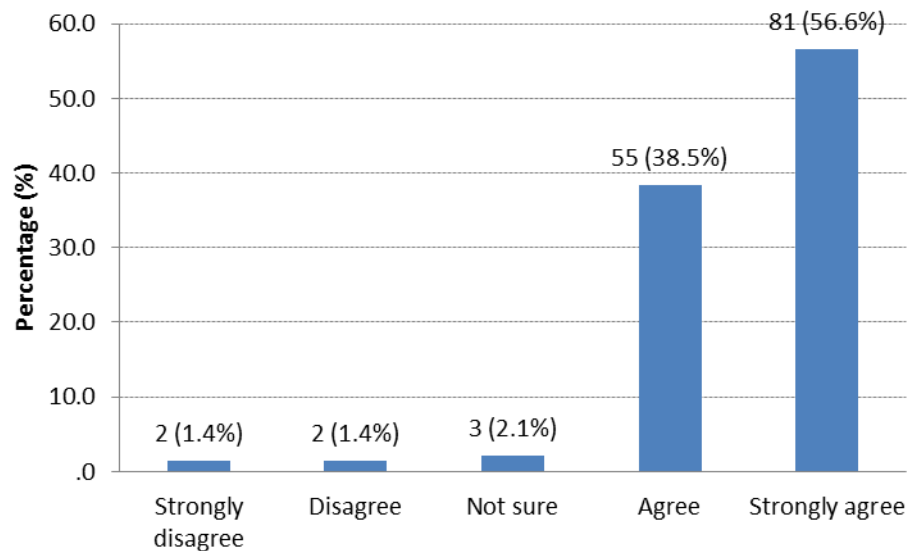
*Figure 4-12: Participants' responses to Q13 - "Religion or strong faith is considered as an important aspect in having a good health", n=145.*

Figure 4-13 illustrates the agreement of the participants with the influence of a healthy lifestyle on their personal wellbeing. Most participants (45.8%) strongly agree and 41.7% agreed that having a healthy lifestyle is important to maintaining personal wellbeing in their new home Australia. While 4.9% of the participants were not sure, 4.2% disagree and 3.5% strongly disagree with the statement that a healthy lifestyle is vital to their wellbeing in Australia.



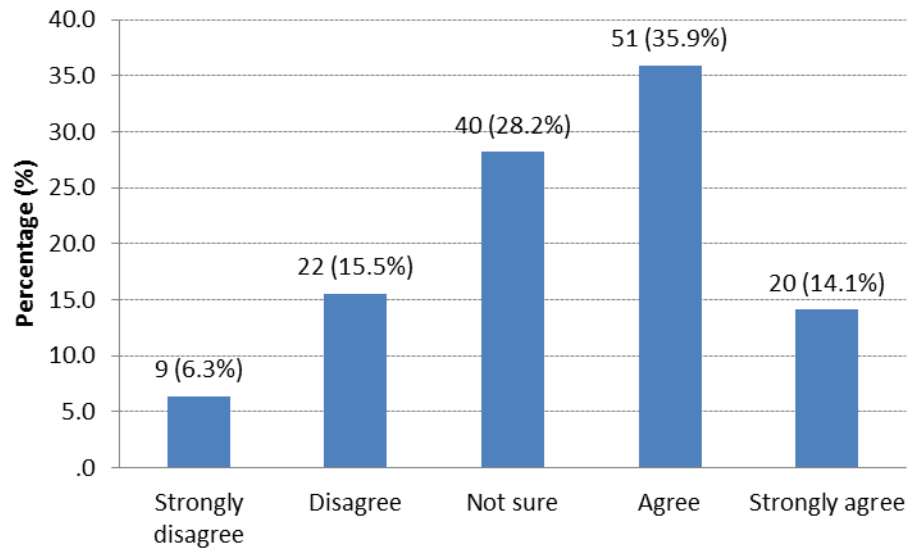
*Figure 4-13: Participants' responses to Q14 – "Healthy lifestyle is vital to my wellbeing in Australia", n=145.*

Majority of the participants affirmed the significance of proper nutrition to their health and wellbeing particularly when they live in a different cultural environment. As shown in Figure 4-14, 56.6% of participants strongly agree and 38.5% agree with the statement “proper nutrition is important for my health and wellbeing”. A small percentage (1.4%) indicated “Disagree” and an equal percentage indicated “Strongly Disagree”.



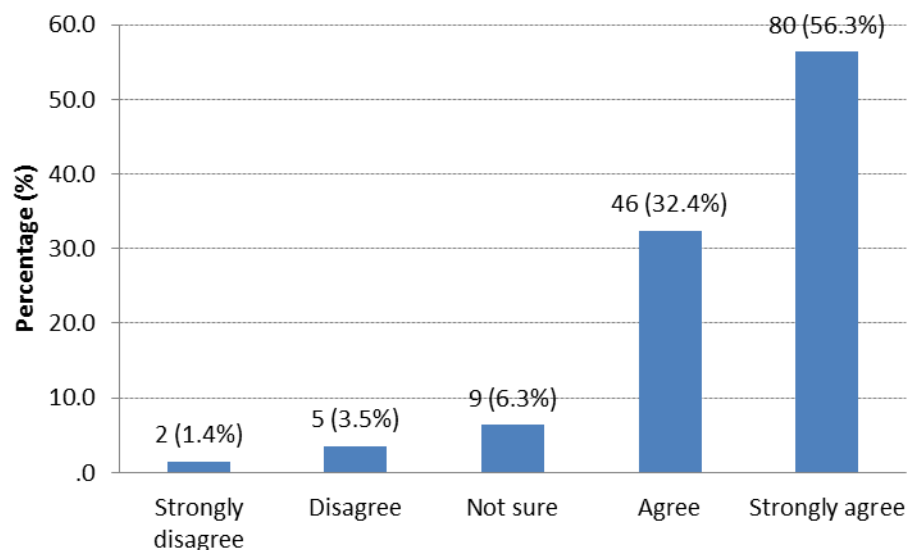
*Figure 4-14: Participants’ responses to Q15 – “Proper nutrition is important to my health and wellbeing”, n=145.*

In Figure 4-15, 35.9% of the participants agree and 14.1% strongly agree that their physical health limits their interaction with others. While 28.2% said “Not Sure”, 15.5% disagree and 6.3% strongly disagree.



*Figure 4-15: Participants' responses to Q16 – "Physical health limits Filipino women's interaction with others", n=145.*

Figure 4-16 shows that 56.3% of the participants strongly agree and 32.4% agree that the care of family is important to them particularly in times of sickness. Only 3.5% disagree and 1.4% strongly disagree.

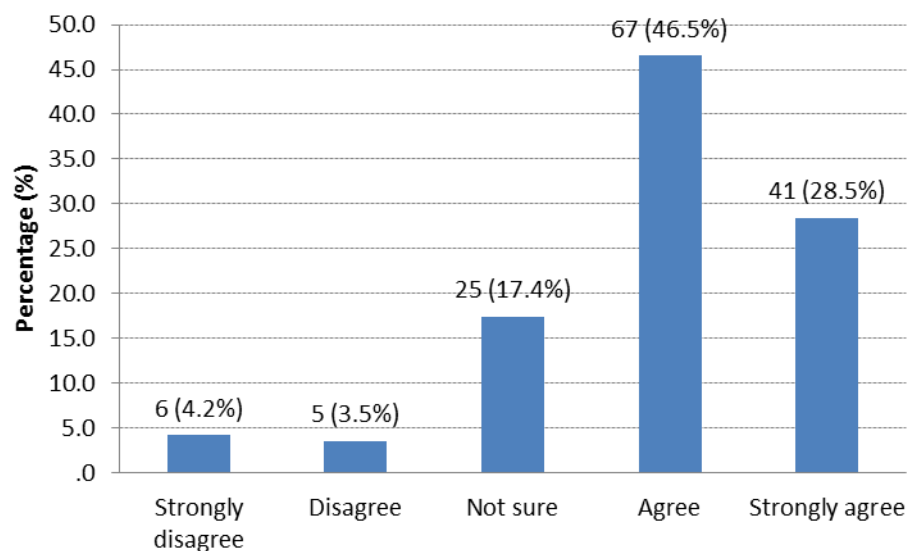


*Figure 4-16: Participants' responses to Q17 – "The care of my family is important to me when I am sick", n=145.*

#### 4.4.2. Access to health care services and its issues

This section presents the result of participants' responses in terms of their views towards access to health care services and issues they have encountered.

Figure 4-17 indicates that 46.5% of the participants agree and 28.5% strongly agree that they received information booklets about health care in Australia when they migrated to Tasmania. , Among the participants, 17.4% were not sure if they received relevant information while 3.5% of the participants disagree and 4.2% strongly disagree that they were given any information.

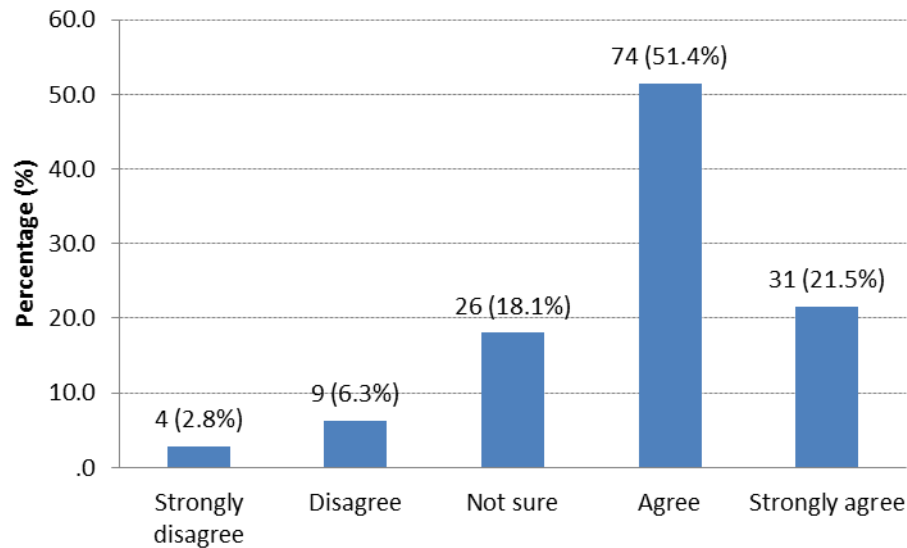


*Figure 4-17: Participants' responses to Q19 - "Information materials about health care services in Australia are useful on my arrival", n=145.*

In accessing health care services, the participants have to interact with health care professionals such as doctors, nurses, midwives, etc. It is important to find out from the participants if the health care professionals are approachable as discussed in Chapter 2 (Literature Review) as most intermarried Filipino women are shy in nature (Dolan, 1991). Therefore, the approachability of health care professionals often helps intermarried Filipino women access available health care services.

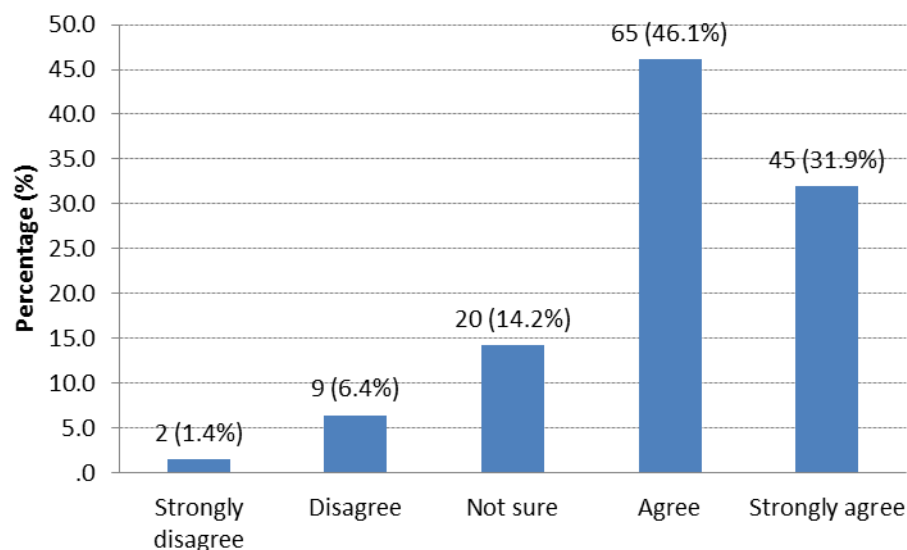
Figure 4-18 shows remarkable results. More than half of the participants (51.4%) agree and 21.5% strongly agree that the health professionals are approachable. Only 6.3% disagree and 2.8% strongly disagree.





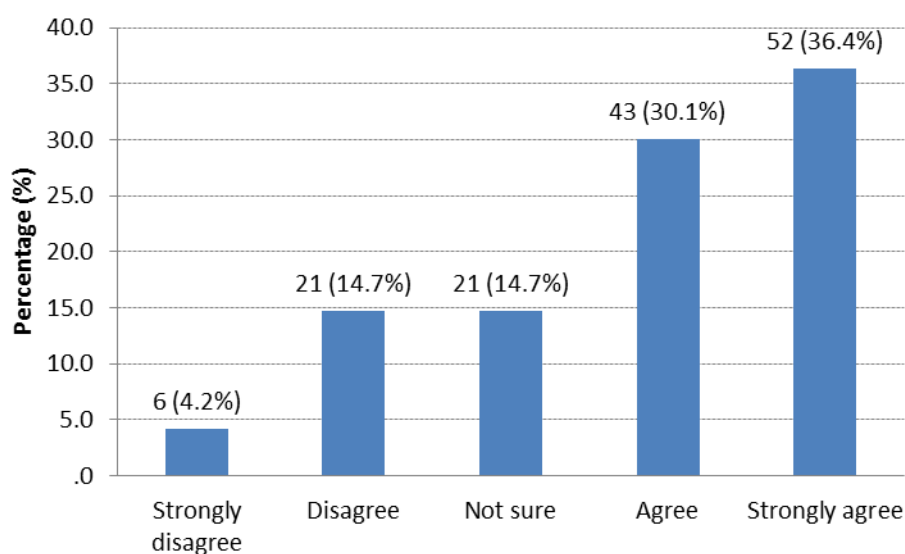
*Figure 4-18: Participants' responses to Q20 – "Health care professionals are very approachable", n=145.*

In Figure 4-19, 46.1% of the participants agree and 31.9% strongly agree that they can usually access health care services when they need to. Only 1.4% strongly disagree and 6.4% disagree.



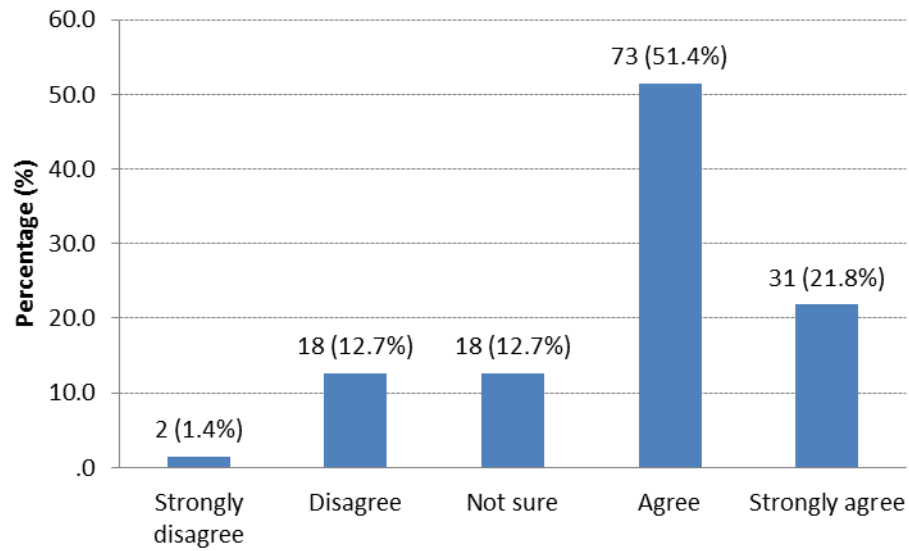
*Figure 4-19: Participants responses to Q21 – "I can usually access health care services (such as: medical care, mental health care, community health care, etc.) when I need them", n=145.*

When participants were asked about their preferences for a female doctor, 36.4% strongly agreed and 30.1% agreed. The results that the intermarried Filipino participants prefer to be treated by a female doctor affirm the nature of them as being shy.



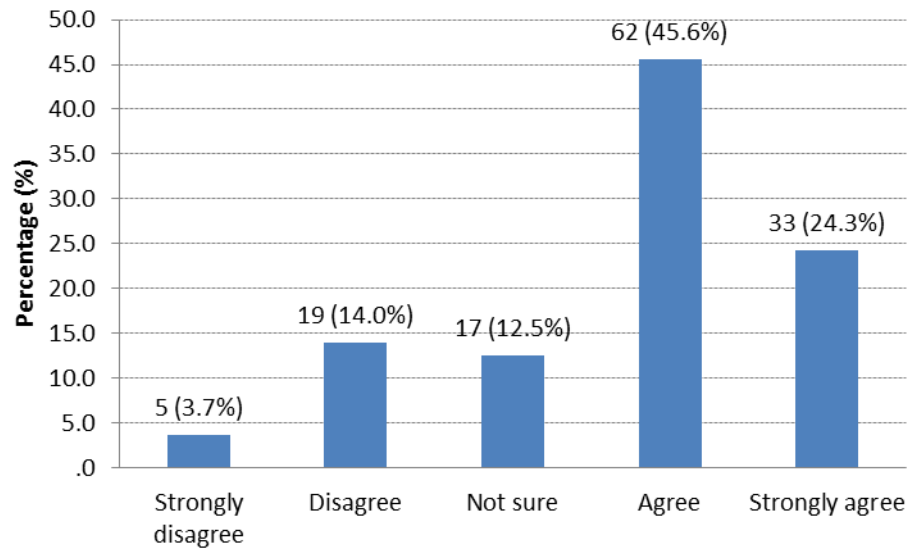
*Figure 4-20: Participants' responses to Q22 – "I prefer to be treated by a female doctor", n=145.*

As shown in Figure 4-21, nearly three fourths of the participants stated that they have learned more about health care services through mass media such as television, magazines, newspaper, etc. (51.4% responded "agree" and 21.8% "strongly agree"). While 12.7% responded "not sure" and 12.7% disagree, only 1.4% responded "strongly disagree" to this question.



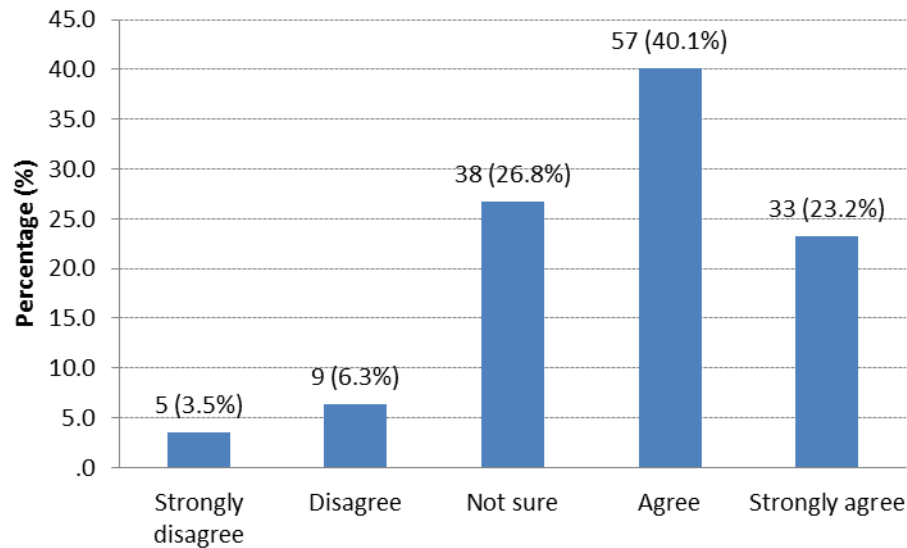
*Figure 4-21: Participants' responses to Q23 – "I learned more about health care services through mass media (TV, magazines, newspaper, etc.)", n=145.*

Due to the advancement of technology, most people access the internet and look for important information they want to know. Figure 4-22 shows that 45.6% of the participants agree and 24.3% strongly agree with the importance of the internet in finding information about health care services. However, 12.5% of the participants responded not sure.



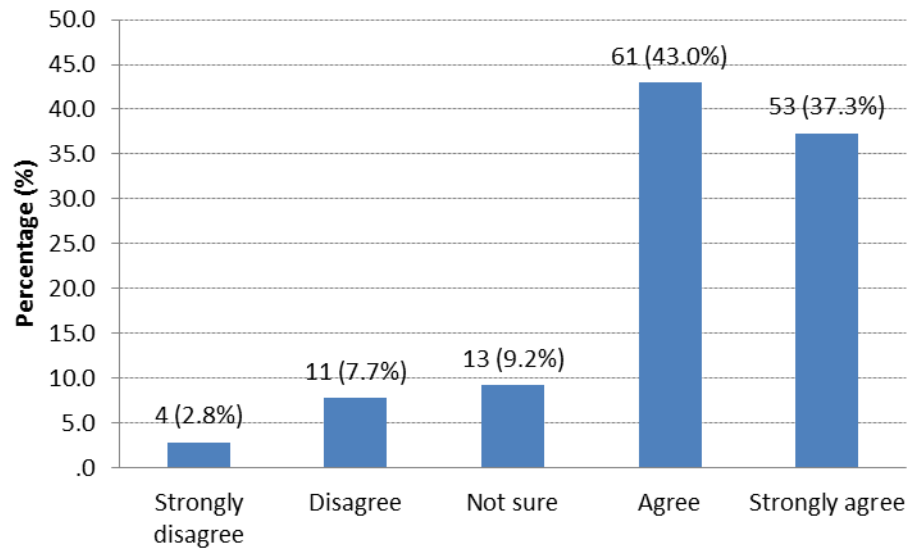
*Figure 4-22: Participants' responses to Q24 – "The internet is helpful for searching of information about health care services", n=145.*

Now living in a different cultural environment, the participants were asked about their views on this statement: "Health care professionals should be aware of migrants' cultural views on health when dealing with them". As shown in Figure 4-23, 40.1 % of the participants agreed and 23.2% of them strongly agreed, while only 26.8% of them said they were not sure. However, the majority viewed it as important.



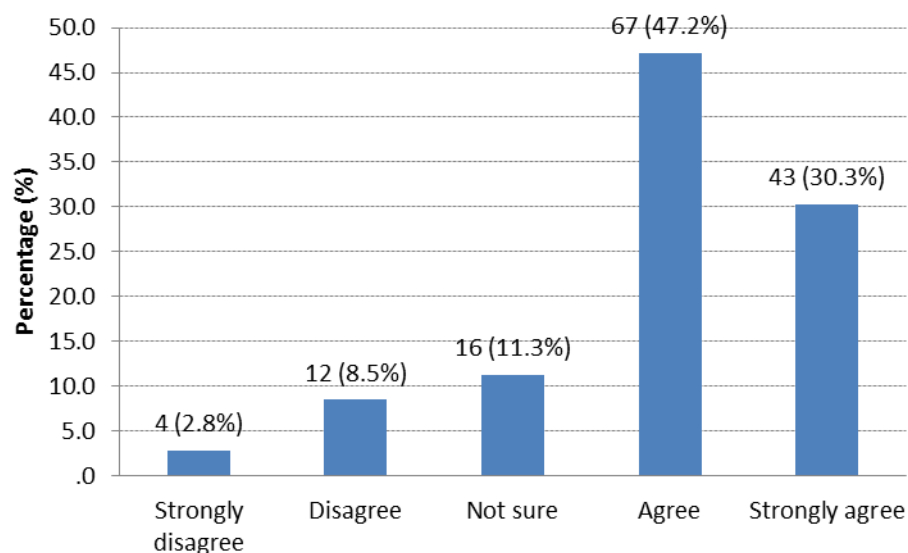
*Figure 4-23: Participants' responses to Q26 – "Health care professionals should be aware of migrants' cultural views", n=145.*

This survey also looked at the views of the participants about the availability of different languages for migrants of different racial backgrounds when they access health care services. Figure 4-24 shows the results: almost all the participants thought that it is important to have different languages available to the migrants, as 43% agree and 37.3% strongly agree with the statement. Only 2.8% strongly disagree.



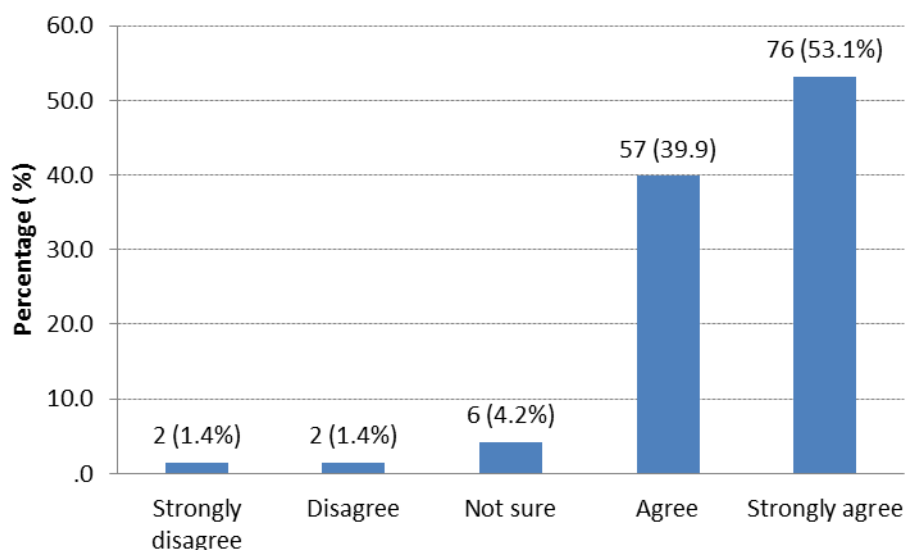
*Figure 4-24: Participants' responses to Q28 – "Information about health/health care services should be available in different languages", n=145.*

Apart from seeing the importance of having different languages available to the migrants, the participants also believed that to facilitate access to health care services and to enhance communication between patients and healthcare professionals, interpreting services should also be available in all health care agencies. As depicted in Figure 4-25, 47.2% of the participants agreed and 30.3% of them strong agreed while only 2.8% strongly disagreed.



*Figure 4-25: Participants' responses to Q29 – "There should be interpreting services available in all health care agencies", n=145.*

When the participants were asked the statement: "Being able to speak English makes it easy for Filipino women to access health care services", more than 90% of them affirmed the importance of English speaking ability. Among all participants, 39.9% agree and 53.1% strongly agree with the statement.



*Figure 4-26: Participants' responses to Q30 – "Being able to speak English makes it easy for Filipino women to access health care services", n=145.*

#### 4.4.3. Personal wellbeing

This section illustrates the perception of the participants on their personal wellbeing in the first two years of their life in Tasmania and their perception of their wellbeing at present.

Figure 4.27 show that the intermarried Filipino women participants have had a good life as a wife. It is evident to the number of participants who rated their “life as a wife” as “very good” and “excellent” during their first 2 years of stay in rural Tasmania as well as at present.

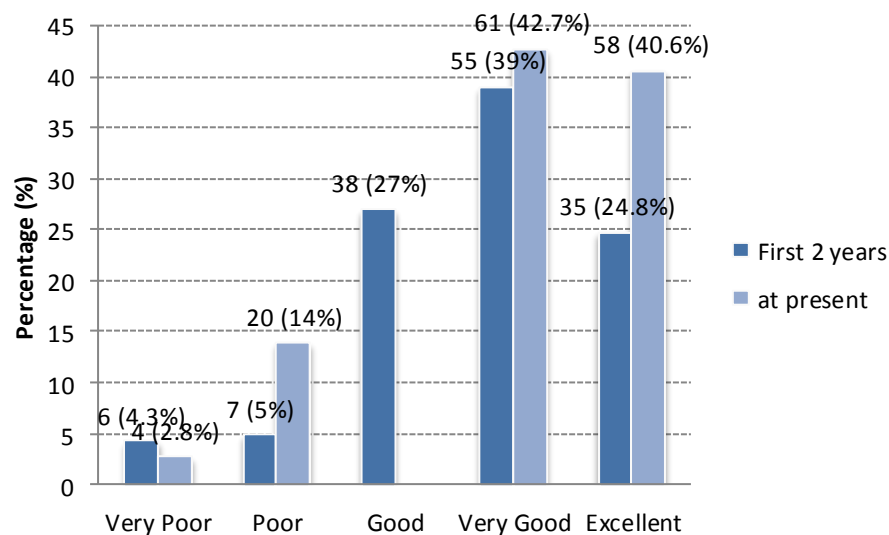


Figure 4-27: Participants' responses to Q31 and Q38 – “Life as a wife”, n=145.

Figure 4-28 illustrates the standard of living of the participants in their first 2 years in rural Tasmania and at present. The results indicate that there are not many differences in the participants' standard of living between their first two years in Australia and at present. Most participants reported that they have a “very good” and “excellent” standard of living. Only very few rated their standard of living as “poor” – 1.4% (first 2 years) and 2.1% (at present).



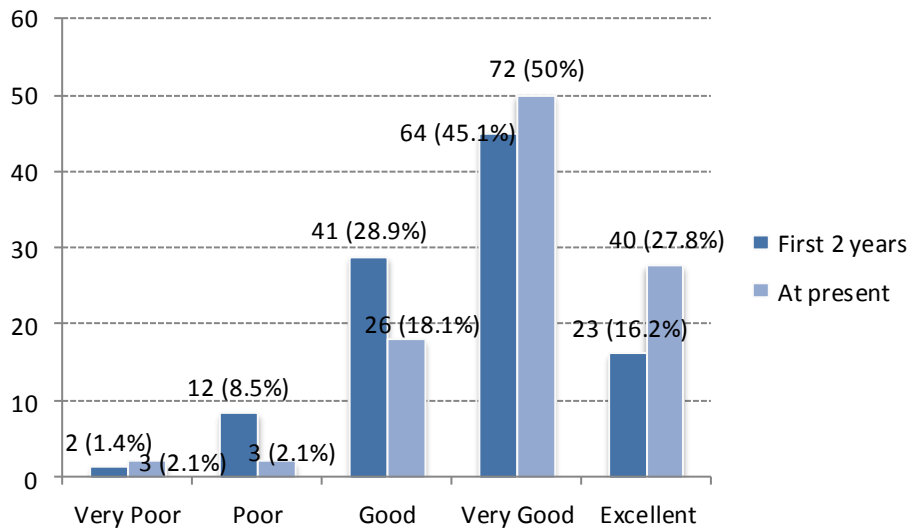


Figure 4-28: Participants' responses to Q32 and Q39 – “Standard of living”, n=145.

With regard to the participants' self-rated health condition, in the “Very Good” category, there is a general improvement from 40.8% (first 2 years) to 51.4% (at present). In the “Good” category, there is a decline from 26.8% (first 2 years) to 18.8% (at present). There is also a decline of about 1-2% in all other categories, as shown in figure 4.29.

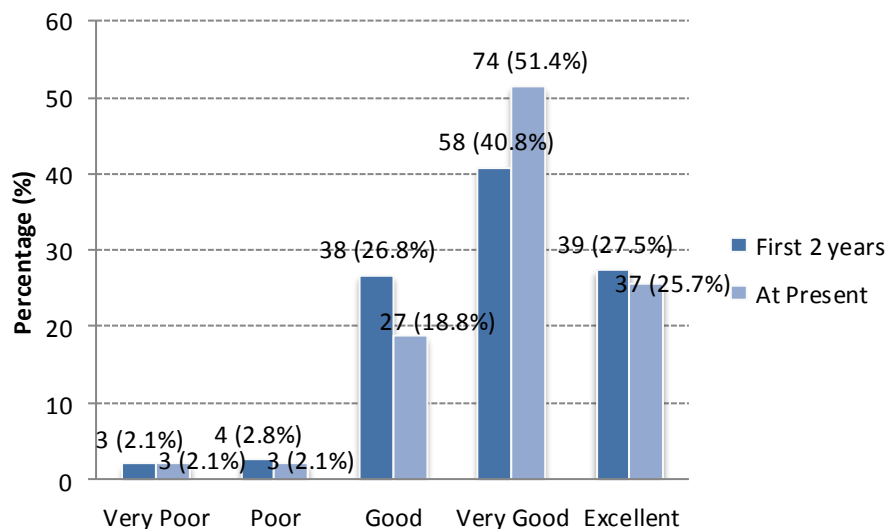


Figure 4-29: Participants' responses to Q33 and Q40 – “Your health”, n=145.

Like the health condition of the participants, their level of achievement in life has also improved significantly from 34% (first 2 years) to 43.8% (at present) in the “Very Good” category. However, the percentage of responses for “Excellent” jumps remarkably from 17% (first 2 years) to 31.3% (at present). It shows that the participants think that they have accomplished something over time as presented in Figure 4-30.

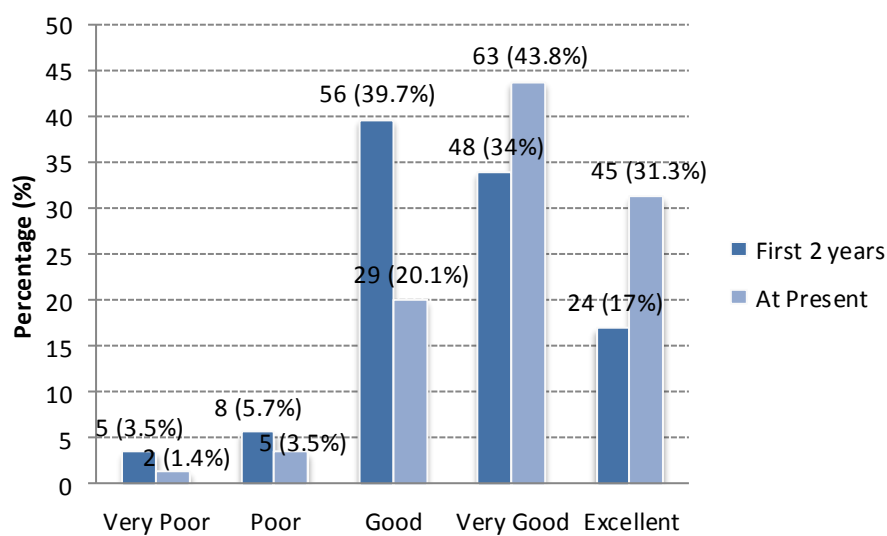


Figure 4-30: Participants’ responses to Q34 and Q41 – “Achievement in life”, n=145.

Figure 4-31 shows the participants’ self-rated personal relationship has diminished from 6.3% (first 2 years) to 0.7% (at present) for “Poor” category; 22.5% (first 2 years) to 10.5% (at present) in the “Good” category; and from 43.7% (first 2 years) to 42.7% (at present) for “Very good”.

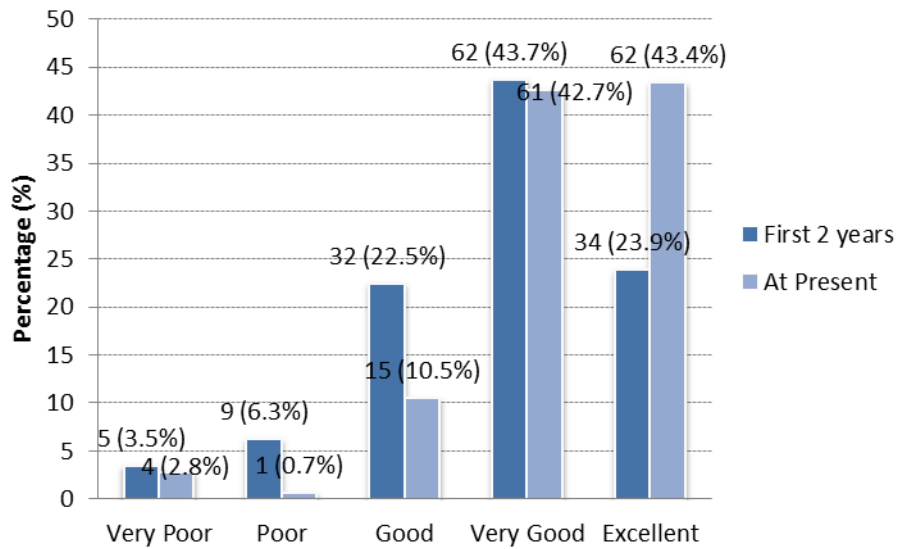


Figure 4-31: Participants' responses to Q35 and Q42 – "Personal relationship",  
n=145.

In terms of safety, Figure 4-32 shows that the participants feel secured in their first 2 years in Tasmania and more so after the first 2 years. As illustrated in Figure 4.32, 44% responded "Very Good" and 25.5% "Excellent" in the first 2 years, while 36.6% responded "Very Good" and 45.8% "Excellent" at present.

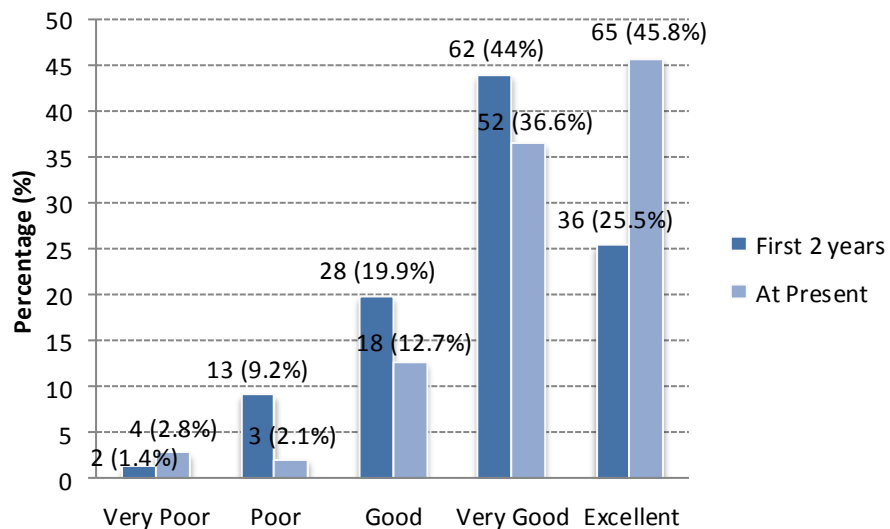


Figure 4-32: Participants' responses to Q36 and Q43 – "How safe do you feel?",  
n=145.

After 2 years, the participants feel that they belong to the community. As shown in Figure 4-33, the rate increases from 38.7% to 46.2% for “Very Good” and from 16.8% to 28.7% for “Excellent”.

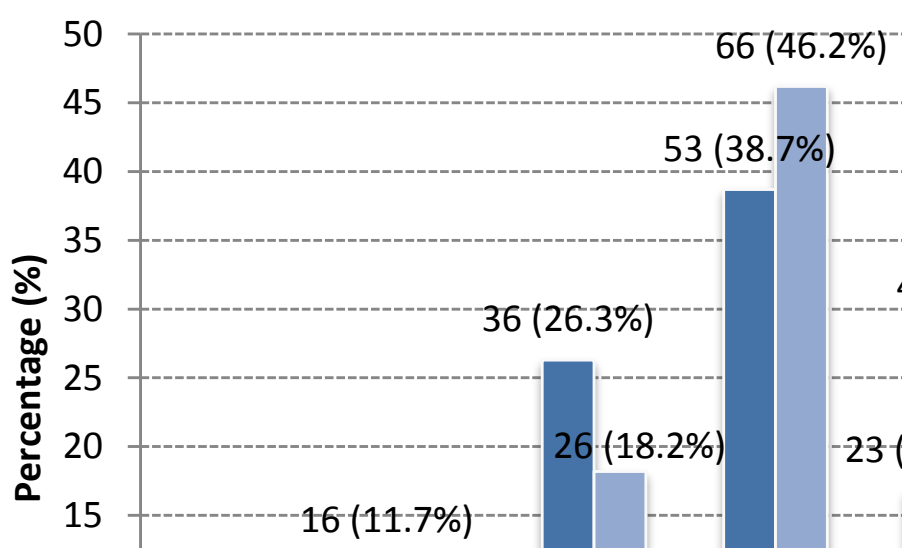
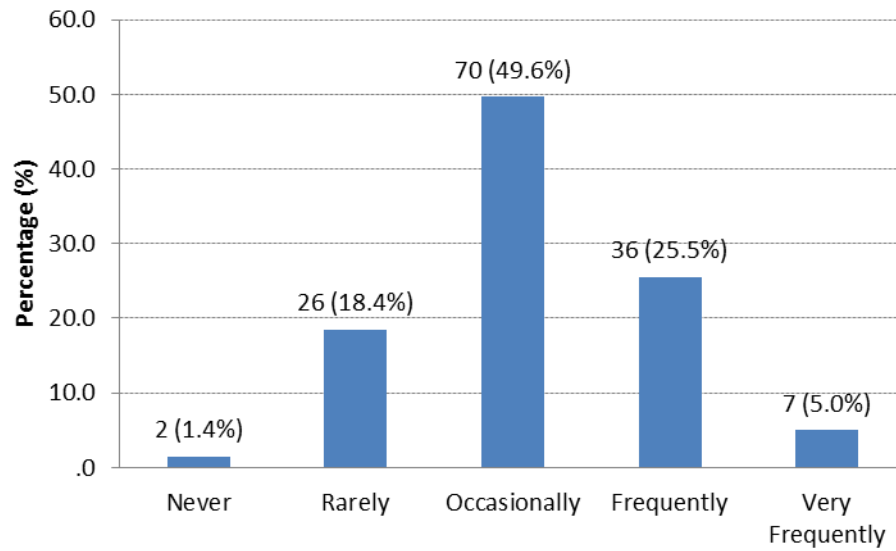


Figure 4-33: Participants’ responses to Q37 and Q44 – “Feeling as being part of the community”, n=145.

#### 4.4.4. General health and wellbeing

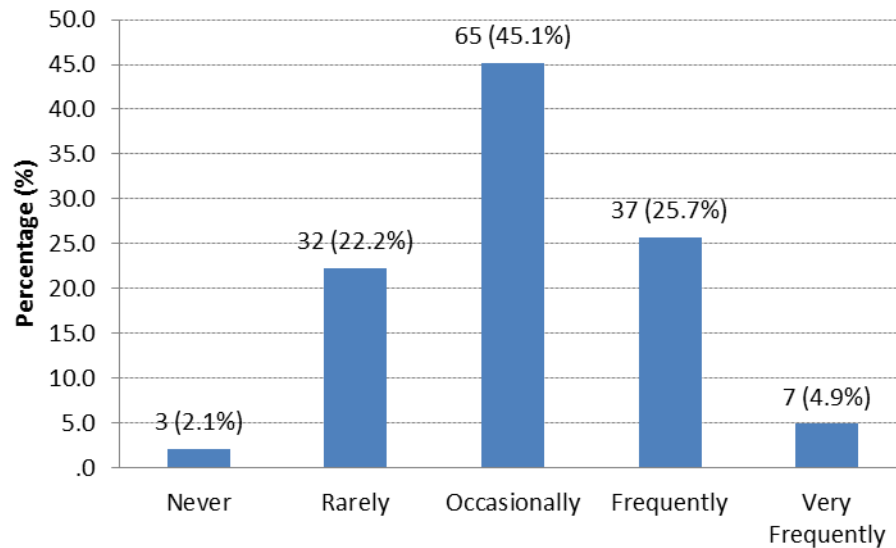
Figures 4-34 – 4-38 reveal the participants’ own perception of their general health and wellbeing (i.e., body pains, visits to a family doctor, see a dentist, see an optician and see a psychologist).

When the participants were asked how often they have body pains, 49.6% of them responded “Occasionally” and 25.5% said “Frequently”, while only 1.4% stated “Never”. Based on these findings, body pains are common to most of the participants.



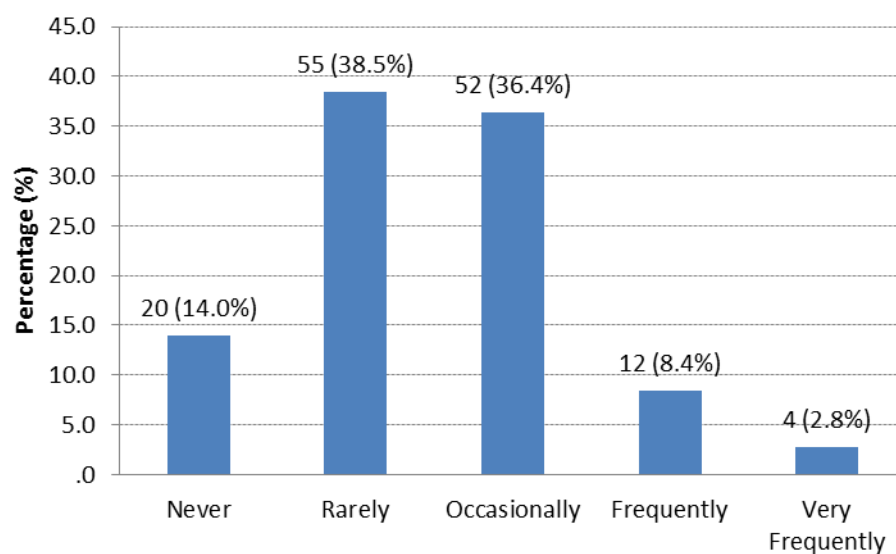
*Figure 4-34: Participants' responses to Q45 – "How often do you have body pains?"*  
n=145.

As discussed earlier, the participants stated that health care professionals are very approachable and they prefer to be treated by a female doctor. Figure 4-35 shows the occurrence of the participants' visits to the doctors: 45.1% of the participants have occasionally visited the doctors; 25.7% of them frequently visit doctor and 22.2% of them rarely see the doctors.



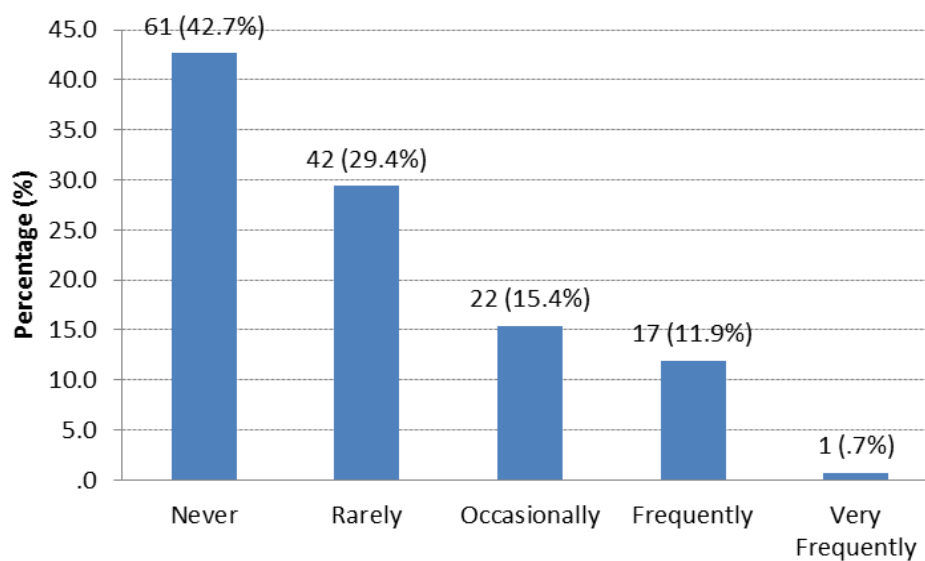
*Figure 4-35: Participants' responses to Q46 – "How often do you visit your family doctor?" n=145.*

Dental health is an important part of one's health and wellbeing. In the survey, it is important to find out how often the participants see the dentists. As depicted in Figure 5-36, 36.4% of the participants said they occasionally see the dentists while 38.5% stated rarely and 14% never. These findings will be further discussed in the discussion chapter.



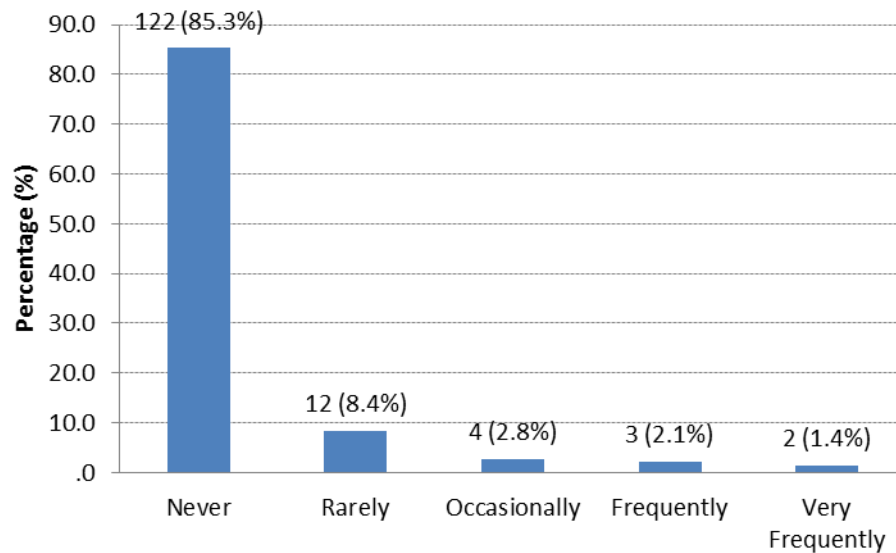
*Figure 4-36: Participants' responses to Q47 – "How often do you need to see a dentist in a year?" n=145.*

The need for a visit to an optician seems to be not so much of an issue to the participants. As presented in Figure 4-37, 42.7% of the participants said they never see an optician, 29.4% of them rarely visit an optician and only 15.4% occasionally.



*Figure 4-37: Participants' responses to Q48 – "How often do you need to see an optician in a year", n=145.*

Figure 4-38 indicates that 85.3% of the participants have never seen a psychologist and only 1.4% sees a psychologist very frequently.



*Figure 4-38: Participants' responses to Q49 – "How often do you see a psychologist in a year", n=145.*

Section 4.4 presents the results of the questions regarding the participants' health and wellbeing which are divided into specific themes such as: health concept; access to health care services and its issues; personal wellbeing; and lastly the general wellbeing. Every theme presented has depicted a significant result. Section 4.4.1 (health concept) and Section 4.4.2 (access to health care services) have similar results, the main highlight of which is that their traditional Filipino beliefs definitely affect the way they view their health and the way they access the services. Section 4.4.3 (personal relationship) has depicted the present and previous (first 2 years in Tasmania) situations of the participants. The results shows a general improvement of their personal wellbeing except for "personal relationship" where a decline at some point is expressed. For Section 4.4.4 (general health and wellbeing), the general results show that the participants are likely to be healthy as most of them only occasionally visit their doctors and dentists. Most of them have never seen an optician and a psychologist as well.

As discussed above, Section 4.4 investigates the health and wellbeing of the participants covering every view the participants have in terms of their health as raised in the questionnaire. The statistics shows significant results in the responses to each of the questions as depicted in the relevant figures.



After studying the participants' responses in terms of their views and attitude towards their health and access to health care services, the section below will then present the different factors that likely affect the views mentioned above.

## **4.5. Analysis of factors affecting the participants' views and attitudes towards their health and wellbeing and their access to health care services**

### **4.5.1. Chi-square test of independence**

After presenting the responses of the participants in terms of their views and attitudes towards their health and wellbeing as well as access to health care services, this section will examine the factors that affect their views and attitudes. Section 4.3 of this chapter has provided the participants' demographic profiles.

As the data collected is not normally distributed, in order to determine if there is any relationship between the demographic characteristics of the participants and their views and attitudes, chi-square test of independence is used. Chi-square test evaluates the dependence among variables, and can be used in the study to test if socio-demographic factors are related to the intermarried Filipino women participants' views and attitudes towards their health and wellbeing as well as access to health care services. A crucial condition of the test is that the number of the cells in the contingency table with the expected number of counts of less than 5 must not be more than 20% of the total number of cells. Therefore, if the number of cells with the expected number of counts of less than 5 exceeds 20%, the table needs to be reorganised by merging the columns or rows to meet the above requirement. For instance, in this study the set of choices like "Strongly disagree and disagree" or "Strongly agree and agree" or "Good and Just fine" were merged to form one group. The age group was also merged like 45-55 years old to over 45 years old depending on the context of the test. In instances where some of the choices only contain zero responses, like for example in "Poor" and "very poor", these categories will not be counted. Thus the choices leave "Good, Very good and Excellent" and so on.

Given the limited scope of this research, the statistical analysis focused only on variables that were identified to be most significant to intermarried Filipino women's views and attitudes on health, health concept and access to health care services in rural Tasmania. The test was conducted using SPSS version 16 with the detail of the test results including cross tabulations, the chi-square value ( $\chi^2$ ), degree of freedom (df) and p-value. Where p-value  $\leq 0.05$ , the result is taken as statistically significant.

#### **4.5.2. Factors that affects the participants' views on health concepts and access to health care services**

Data analysis results indicate that three out of the six independent variables came up to be significant factors affecting the participants' views in terms of their health concept and access to health care services. Below are the tables that show the significant results.

##### **4.5.2.1. Length of stay in Tasmania**

Table 4-1 illustrates the significant relationship between participants' views and attitude towards the absence of Filipino food as affecting their diet as  $\chi^2 = 10.11$ , df = 3, p-value = 0.0177 < 0.05. Findings show that the longer the participants' live in Tasmania the less the effect of the absence of Filipino food choices to their diet while for participants' who have live in Tasmania for a period of 2-10 years it does affect their diet. This means that the longer they live in Tasmania the better they can adjust for the food available in the host country.

Table 4-1: *Chi-square test on the relationship of participant's English language proficiency and their views on the absence of Filipino food affect their diet.*

| Q4. Length of stay in Tasmania |            | Q8. Absence of Filipino food choices affects my diet. |       |        |
|--------------------------------|------------|---|-------|--------|
|                                |            | Disagree  | Agree | Total  |
| <b>Under 2 years</b>           | Count      | 7   | 8     | 15     |
|                                | % of Total | 4.8%  | 5.5%  | 10.3%  |
| <b>5 to 10 years</b>           | Count      | 7   | 16    | 23     |
|                                | % of Total | 4.8%  | 11.0% | 15.9%  |
| <b>More than 5 to 10 years</b> | Count      | 26  | 12    | 38     |
|                                | % of Total | 17.9%   | 8.3%  | 26.2%  |
| <b>Over 10 years</b>           | Count      | 43  | 26    | 69     |
|                                | % of Total | 29.7%   | 17.9% | 47.6%  |
| <b>Total</b>                   | Count      | 83  | 62    | 145    |
|                                | % of Total | 57.2%   | 42.8% | 100.0% |

$$\chi^2 = 10.11, df = 3, p\text{-value} = 0.0177 < 0.05$$

#### 4.5.2.2. English language proficiency

The participants are migrants therefore it is important for them to have the ability to speak English language. Table 4-2 shows that there is a significant relationship between participants' English language proficiency to their views towards health care professionals as very approachable as the p-value=0.0158<.05. This finding explains that the more participants' can speak the language the better they can approach and communicate health care professionals.

Table 4-2: *Chi-square test of the relationship between participant's English language proficiency and their views on health care professionals are very approachable.*

| Q6. English language proficiency |            | Q15. Health care professionals are very approachable. |       |                |        |
|----------------------------------|------------|---|-------|----------------|--------|
|                                  |            | Disagree  | Agree | Strongly Agree | Total  |
| <b>Good</b>                      | Count      | 6   | 9     | 11             | 26     |
|                                  | % of Total | 4.2%  | 6.3%  | 7.6%           | 18.1%  |
| <b>Just fine</b>                 | Count      | 33  | 65    | 20             | 118    |
|                                  | % of Total | 22.9%   | 45.1% | 13.9%          | 81.9%  |
| <b>Total</b>                     | Count      | 39  | 74    | 31             | 144    |
|                                  | % of Total | 27.1%   | 51.4% | 21.5%          | 100.0% |

$$\chi^2 = 8.29, df = 2, p\text{-value} = 0.0158 < 0.05$$

Table 4-2 illustrates the significance of participants' English language proficiency towards the way they view the approachability of the health care professionals. However, Table 4-3 presents the relationship between participants' English language proficiency and their views about health care professionals awareness of migrants' cultural views on dealing with them as the  $p\text{-value}=0.0322<0.05$ .

Table 4-3: *Chi-square test of the relationship between participant's English language proficiency and their views on health care professionals should be aware of migrants' cultural views on dealing with them.*

| Q6. Proficiency of English Language |            | Q26. Health care professionals should be aware of migrants' cultural views on health when dealing with them. |       |        |
|-------------------------------------|------------|--|-------|--------|
|                                     |            | Disagree   | Agree | Total  |
| <b>Excellent</b>                    | Count      | 9  | 17    | 26     |
|                                     | % of Total | 6.3%   | 12.0% | 18.3%  |
| <b>Good</b>                         | Count      | 30   | 65    | 95     |
|                                     | % of Total | 21.1%  | 45.8% | 66.9%  |
| <b>Just Fine</b>                    | Count      | 13   | 8     | 21     |
|                                     | % of Total | 9.2%   | 5.6%  | 14.8%  |
| <b>Total</b>                        | Count      | 52   | 90    | 142    |
|                                     | % of Total | 36.6%  | 63.4% | 100.0% |

$\chi^2 = 6.87$ ,  $df = 2$ ,  $p\text{-value} = 0.0322 < 0.05$

Illustrated in Table 4-4 participants who have "Good" English language skills are more likely to use Internet to search for information about health care services. Having the knowledge to speak English is an advantage for them because the general language used in the internet is English. In this case they can understand what they are searching for. Therefore, data analysis in this regard shows a significant relationship as  $\chi^2 = 14.01$ ,  $df = 4$ ,  $p\text{-value} = 0.0073 < 0.05$ .

Table 4-4: Chi-square test of the relationship between participant's English language proficiency and their views on internet as a helpful tool for searching information about health care services.

| Q6. English language proficiency |            | Q30. The Internet is helpful for my searching of information about health care services. |       |                |        |
|----------------------------------|------------|--|-------|----------------|--------|
|                                  |            | Disagree   | Agree | Strongly Agree | Total  |
| <b>Excellent</b>                 | Count      | 7  | 12    | 7              | 26     |
|                                  | % of Total | 5.1%   | 8.8%  | 5.1%           | 19.9%  |
| <b>Good</b>                      | Count      | 21   | 47    | 21             | 89     |
|                                  | % of Total | 15.4%  | 34.6% | 15.4%          | 65.4%  |
| <b>Just fine</b>                 | Count      | 13   | 3     | 5              | 21     |
|                                  | % of Total | 9.6%   | 2.2%  | 3.7%           | 15.4%  |
| <b>Total</b>                     | Count      | 41   | 62    | 33             | 136    |
|                                  | % of Total | 30.1%  | 45.6% | 24.3%          | 100.0% |

$\chi^2 = 14.01$ ,  $df = 4$ ,  $p\text{-value} = 0.0073 < 0.05$

#### 4.5.2.3. Highest level of education

The highest level of education is one of the factors that affect participants' views on health and access to health care services.

Table 4-5 shows the relationship between participant's highest level of education and their views about the usefulness of internet to their access of health care services as the  $p\text{-value}=0.0469<0.05$ . Most of the number of participants' who were university and tertiary graduate responded "Agree" and "Strongly agree". This analysis shows that these participants likely know how to access and gather information about the health care services from the internet or web browsing.

Table 4-5: *Chi-square test of the relationship between participant's highest level of education and their views on towards the internet as helpful for searching of information about health care services.*

| Q2. Highest level of education     |            | Q30. The Internet is helpful for my searching of information about health care services. |       |                |        |
|------------------------------------|------------|--|-------|----------------|--------|
|                                    |            | Disagree   | Agree | Strongly Agree | Total  |
| <b>Primary and High School</b>     | Count      | 13   | 7     | 4              | 24     |
|                                    | % of Total | 9.6%   | 5.1%  | 2.9%           | 17.6%  |
| <b>Vocational/TAFE</b>             | Count      | 12   | 16    | 11             | 39     |
|                                    | % of Total | 8.8%   | 11.8% | 8.1%           | 28.7%  |
| <b>University/Tertiary/ Others</b> | Count      | 16   | 39    | 18             | 73     |
|                                    | % of Total | 11.8%  | 28.7% | 13.2%          | 53.7%  |
| <b>Total</b>                       | Count      | 41   | 62    | 33             | 136    |
|                                    | % of Total | 30.1%  | 45.6% | 24.3%          | 100.0% |

$\chi^2 = 9.64$ ,  $df = 4$ ,  $p\text{-value} = 0.0469 < 0.05$

#### 4.5.3. Factors that affect participant's personal wellbeing

##### 4.5.3.1. Highest level of Education

As depicted in Table 4-6 there is a significant relationship with participant's life as a wife in a new cultural environment from their highest level of education where the  $\chi^2 = 13.08$ ,  $df = 4$ ,  $p\text{-value} = 0.0109 < 0.05$ . Participants who were highly educated are more likely the ones who claimed to have a "Good" – 13.5%; "Very Good" – 27%; and "Excellent" – 11.3% life as a wife.

Table 4-6 *Chi-square test of the relationship between participant's highest level of education and their views about their life as a wife.*

| Q2. Highest level of education       |            | Q31. Life as a wife |           |           |        |
|--------------------------------------|------------|---------------------|-----------|-----------|--------|
|                                      |            | Good                | Very Good | Excellent | Total  |
| <b>Primary and High School Educ.</b> | Count      | 10                  | 7         | 9         | 26     |
|                                      | % of Total | 7.1%                | 5.0%      | 6.4%      | 18.4%  |
| <b>Vocational/TAFE Education</b>     | Count      | 22                  | 10        | 10        | 42     |
|                                      | % of Total | 15.6%               | 7.1%      | 7.1%      | 29.8%  |
| <b>Tertiary/University Education</b> | Count      | 19                  | 38        | 16        | 73     |
|                                      | % of Total | 13.5%               | 27.0%     | 11.3%     | 51.8%  |
| <b>Total</b>                         | Count      | 51                  | 55        | 35        | 141    |
|                                      | % of Total | 36.2%               | 39.0%     | 24.8%     | 100.0% |

$\chi^2 = 13.08$ ,  $df = 4$ ,  $p\text{-value} = 0.0109 < 0.05$

#### 4.5.3.2. Length of stay in Tasmania

Table 4-7 illustrates the significant relationship between participants' length of stay in Tasmania towards their views on "How safe they feel" living in the host country as  $\chi^2 = 13.08$ ,  $df = 4$ ,  $p\text{-value} = 0.0109 < 0.05$ . This analysis shows that the longer they live in Tasmania the safer they feel.

Table 4-7: *Chi-square test of the relationship between participants' length of stay in Tasmania towards their views on "How safe they feel".*

| Q4. Length of stay in Tasmania |            | Q43. How safe you feel? |           |           |        |
|--------------------------------|------------|-------------------------|-----------|-----------|--------|
|                                |            | Good                    | Very Good | Excellent | Total  |
| <b>2-5 years</b>               | Count      | 10                      | 17        | 8         | 35     |
|                                | % of Total | 7.1%                    | 12.1%     | 5.7%      | 24.8%  |
| <b>More than 5 to 10 years</b> | Count      | 10                      | 11        | 17        | 38     |
|                                | % of Total | 7.1%                    | 7.8%      | 12.1%     | 27.0%  |
| <b>Over 10 years</b>           | Count      | 23                      | 34        | 11        | 68     |
|                                | % of Total | 16.3%                   | 24.1%     | 7.8%      | 48.2%  |
| <b>Total</b>                   | Count      | 43                      | 62        | 36        | 141    |
|                                | % of Total | 30.5%                   | 44.0%     | 25.5%     | 100.0% |

$\chi^2 = 13.08$ ,  $df = 4$ ,  $p\text{-value} = 0.0254 < 0.05$

Depicted in table 4-8 the significant relationship between participants' views towards their views on "personal relationship" ( $\chi^2 = 9.63$ ,  $df = 4$ ,  $p\text{-value} = 0.0471 < 0.05$ ). The result shows that the longer the participants' leave in Tasmania the better their personal relationship with their husband, in-laws and family.

Table 4-8: *Chi-square test of the relationship between participants' length of stay in Tasmania towards their views on "personal relationship".*

| Q4. Length of stay in Tasmania |            | Q35. Personal relationship |           |           |        |
|--------------------------------|------------|----------------------------|-----------|-----------|--------|
|                                |            | Good                       | Very Good | Excellent | Total  |
| <b>2 to 5 years</b>            | Count      | 6                          | 21        | 8         | 35     |
|                                | % of Total | 4.2%                       | 14.8%     | 5.6%      | 24.6%  |
| <b>More than 5 to 10 years</b> | Count      | 10                         | 18        | 10        | 38     |
|                                | % of Total | 7.0%                       | 12.7%     | 7.0%      | 26.8%  |
| <b>Over 10 years</b>           | Count      | 30                         | 23        | 16        | 69     |
|                                | % of Total | 21.1%                      | 16.2%     | 11.3%     | 48.6%  |
| <b>Total</b>                   | Count      | 46                         | 62        | 34        | 142    |
|                                | % of Total | 32.4%                      | 43.7%     | 23.9%     | 100.0% |

$\chi^2 = 9.63$ ,  $df = 4$ ,  $p\text{-value} = 0.0471 < 0.05$

#### 4.5.3.3. Area of location from the Philippines

Presented in table 4-9, the area of location from the Philippines where the participants come from shows a significant relationship towards their standard of living as  $\chi^2 = 14.24$ ,  $df = 3$ ,  $p\text{-value} = 0.0026 < 0.05$ . Analysis shows that participants' coming from the urban areas has a better standard of living than those from the rural areas.

Table 4-9: *Chi-square test of the relationship between participants' area of location from the Philippines towards their views of "Standard of living".*

| Q3. Area of location in the Philippines |            | Q32. Standard of living |       |           |           |        |
|---|------------|-------------------------|-------|-----------|-----------|--------|
|   |            | Fair                    | Good  | Very Good | Excellent | Total  |
| Urban                                   | Count      | 9                       | 30    | 40        | 6         | 85     |
|   | % of Total | 6.3%                    | 21.1% | 28.2%     | 4.2%      | 59.9%  |
| Rural                                   | Count      | 5                       | 11    | 24        | 17        | 57     |
|   | % of Total | 3.5%                    | 7.7%  | 16.9%     | 12.0%     | 40.1%  |
| Total                                   | Count      | 14                      | 41    | 64        | 23        | 142    |
|   | % of Total | 9.9%                    | 28.9% | 45.1%     | 16.2%     | 100.0% |

$\chi^2 = 14.24$ ,  $df = 3$ ,  $p\text{-value} = 0.0026 < 0.05$

#### 4.5.3.4. English language

Table 4-10 illustrates a significant relationship between participants English language proficiency towards their standard of living as the  $p\text{-value}$  is 0.0202. Participants' who speak "Good" English claimed that they have a "Very Good" standard of living that is 52.6% while 30.8% claimed to have "Good" standard of living.

Table 4-10: *Chi-square test of the relationship between participant's English language proficiency and their views about their standard of living.*

| Q6. English language proficiency |            | Q32. Standard of living |           |        |
|----------------------------------|------------|-------------------------|-----------|--------|
|                                  |            | Good                    | Very Good | Total  |
| Good                             | Count      | 41                      | 70        | 111    |
|                                  | % of Total | 30.8%                   | 52.6%     | 83.5%  |
| Just fine                        | Count      | 14                      | 8         | 22     |
|                                  | % of Total | 10.5%                   | 6.0%      | 16.5%  |
| Total                            | Count      | 55                      | 78        | 133    |
|                                  | % of Total | 41.4%                   | 58.6%     | 100.0% |



$\chi^2 = 5.40$ ,  $df = 1$ ,  $p\text{-value} = 0.0202 < 0.05$

Like education, participants' ability to speak English affects their achievement in life. As described in Table 4-11, the better participants speak English, the more they can achieve in life. From the findings shown, participants who claimed to have "Good" English rated their achievement in life as "Good" that is 30.5%, and "Very good" 36.2%. Therefore this result shows significant relationship as  $p\text{-value} = .0017$ .

Table 4-11: *Chi-square test of the relationship between participant's English language proficiency and their views on their achievement in life.*

| Q6. English language proficiency |            | Q34. Achievement in life |           |        |
|----------------------------------|------------|--------------------------|-----------|--------|
|                                  |            | Good                     | Very Good | Total  |
| <b>Excellent</b>                 | Count      | 8                        | 17        | 25     |
|                                  | % of Total | 5.7%                     | 12.1%     | 17.7%  |
| <b>Good</b>                      | Count      | 43                       | 51        | 94     |
|                                  | % of Total | 30.5%                    | 36.2%     | 66.7%  |
| <b>Just fine</b>                 | Count      | 18                       | 4         | 22     |
|                                  | % of Total | 12.8%                    | 2.8%      | 15.6%  |
| <b>Total</b>                     | Count      | 69                       | 72        | 141    |
|                                  | % of Total | 48.9%                    | 51.1%     | 100.0% |

$\chi^2 = 12.77$ ,  $df = 2$ ,  $p\text{-value} = 0.0017 < 0.05$

In many instances, participants' ability to speak English shows a significant relationship with their particular views and attitudes like their personal relationship with the family and husband. As presented in Table 4-12, 40.8% of the participants who have a "Good" English speaking skill also display a "Very Good" personal relationship. Thus this finding also shows a significant result as  $p\text{-value}$  is 0.0024.

Table 4-12: *Chi-square test of the relationship between participant's English language proficiency and their views towards personal relationship.*

| Q6. English language proficiency |            | Q35. Personal relationship |           |           |        |
|----------------------------------|------------|----------------------------|-----------|-----------|--------|
|                                  |            | Good                       | Very Good | Excellent | Total  |
| <b>Good</b>                      | Count      | 32                         | 58        | 30        | 120    |
|                                  | % of Total | 22.5%                      | 40.8%     | 21.1%     | 84.5%  |
| <b>Just fine</b>                 | Count      | 14                         | 4         | 4         | 22     |
|                                  | % of Total | 9.9%                       | 2.8%      | 2.8%      | 15.5%  |
| <b>Total</b>                     | Count      | 46                         | 62        | 34        | 142    |
|                                  | % of Total | 32.4%                      | 43.7%     | 23.9%     | 100.0% |

$\chi^2 = 12.08$ ,  $df = 2$ ,  $p\text{-value} = 0.0024 < 0.05$

As depicted in Table 4-13, participants' who speak "Good" English do feel safe as they rate their safety as "Very Good" 33.3% and 16.3% for "Excellent".

Table 4-13: *Chi-square test of the relationship between participant's English language proficiency towards their views on how safe they feel in a new cultural environment.*

| Q6. English language proficiency |            | Q36. How safe you feel |           |           |        |
|----------------------------------|------------|------------------------|-----------|-----------|--------|
|                                  |            | Good                   | Very Good | Excellent | Total  |
| <b>Excellent</b>                 | Count      | 5                      | 11        | 10        | 26     |
|                                  | % of Total | 3.5%                   | 7.8%      | 7.1%      | 18.4%  |
| <b>Good</b>                      | Count      | 23                     | 47        | 23        | 93     |
|                                  | % of Total | 16.3%                  | 33.3%     | 16.3%     | 66.0%  |
| <b>Just fine</b>                 | Count      | 15                     | 4         | 3         | 22     |
|                                  | % of Total | 10.6%                  | 2.8%      | 2.1%      | 15.6%  |
| <b>Total</b>                     | Count      | 43                     | 62        | 36        | 141    |
|                                  | % of Total | 30.5%                  | 44.0%     | 25.5%     | 100.0% |

$$\chi^2 = 19.54, df = 4, p\text{-value} = 0.0006 < 0.05$$

English language is the native language of the host country. Therefore to be able to speak the language directly affects the participants' views and attitudes as being part of the community. Illustrated in Table 4-14, participants who have claimed to speak "Good" English feel belonging to the community as 38.7% responded for "Very Good" and 27.7% "Good" as having feel a part of a community. These findings indicate a significant relationship between their speaking English proficiency from their views on feeling part of the community  $\chi^2=69.067, df=16, p\text{-value}=0.000<0.05$ .

Table 4-14: *Chi-square test of the relationship between participant's English language proficiency and their views on feeling part of the community.*

| Q6. English language proficiency |            | Q37. Felling part of the community |           |        |
|----------------------------------|------------|------------------------------------|-----------|--------|
|                                  |            | Good                               | Very Good | Total  |
| <b>Excellent</b>                 | Count      | 9                                  | 17        | 26     |
|                                  | % of Total | 6.6%                               | 12.4%     | 19.9%  |
| <b>Good</b>                      | Count      | 38                                 | 53        | 91     |
|                                  | % of Total | 27.7%%                             | 38.7%     | 66.4%  |
| <b>Just fine</b>                 | Count      | 14                                 | 6         | 20     |
|                                  | % of Total | 10.2%                              | 4.4%      | 14.6%  |
| <b>Total</b>                     | Count      | 61                                 | 76        | 137    |
|                                  | % of Total | 44.5%                              | 55.5%     | 100.0% |

$$\chi^2 = 6.57, df = 2, p\text{-value} = 0.0374 < 0.05$$

Similarly section 4.5.4 also detected a factor that significantly affects participants' general health and wellbeing.

#### 4.5.4. Factor that affect participant's general health and wellbeing

##### 4.5.4.1. English language

As described in Table 4-15, there is a significant relationship between participants English language proficiency to their views and attitudes in visiting their family doctor. Having the ability to speak "Good" English made some of the participants comfortable to visits their family doctor like for example for a regular check-up. In the questionnaire, however, participants were asked as to how often in a year they have visited their family doctor? For participants who have "Good" English, they "Occasionally" visit their family doctor as 33.3% and 17.4% for "frequent" visits to the doctor. Participant's ability to speak "Good" English indicates a significant relationship to their views and attitudes as the p-value is .0120.

Table 4-15: *Chi-square test of the relationship between participants English language proficiency and their views and attitudes on how often in a year they visit their family doctor.*

| English language proficiency |            | Visit family doctor |              |            |        |
|------------------------------|------------|---------------------|--------------|------------|--------|
|                              |            | Rarely              | Occasionally | Frequently | Total  |
| <b>Excellent</b>             | Count      | 10                  | 10           | 6          | 26     |
|                              | % of Total | 6.9%                | 6.9%         | 4.2%       | 18.1%  |
| <b>Good</b>                  | Count      | 23                  | 48           | 25         | 96     |
|                              | % of Total | 16.0%               | 33.3%        | 17.4%      | 66.7%  |
| <b>Just fine</b>             | Count      | 2                   | 7            | 13         | 22     |
|                              | % of Total | 1.4%                | 4.9%         | 9.0%       | 15.3%  |
| <b>Total</b>                 | Count      | 35                  | 65           | 44         | 144    |
|                              | % of Total | 24.3%               | 45.1%        | 30.6%      | 100.0% |

$$\chi^2 = 12.85, df = 4, p\text{-value} = 0.0120 < 0.05$$

In terms of the general health and wellbeing of the participants only two factors found to be significant and that is their age group and English language proficiency. In the survey questionnaire there were five questions raised in this section, however only two questions came out to be significant with the given factors after doing the chi-square test analysis.

## 4.6. Conclusion

Two main points highlighted in this chapter: First, having used questionnaire as a research tool implies an evident-based research as have illustrated through tables and figures. Second, three aspects were given importance to display what the data finding brings to the existing body of knowledge such as participants' views and attitude towards their health and wellbeing, their access to health care services and the different factors that likely affects their health and wellbeing as well as to their access to health care services.

To make a distinction, the three aspects mentioned above will be explained individually. As presented data findings statistically show that participants' views and attitude significantly affect their health and wellbeing. In most cases, participants' responded "Agree" and "Strongly agree" to the research questions like for example: I still hold traditional Filipino beliefs and views in looking after my health; Religion or strong faith is considered as an important aspect in having good health; and I prefer to be treated by a female doctor. These findings have also enriched and confirm the results obtained from the interview analysis (see chapter 5).

In terms of the access to health care services, notable data findings were found. Statistically participants' likely don't have much problem in accessing health care services as they can access it when needed to. The responses, however, for the following questions: Q30. Being able to speak English makes it easy for Filipino women to access health care services; Q29. There should be interpreting services available for migrants in any health care agencies; and Q28. Information about health/health care should be available in different languages have implied the importance of English language to their access of health care services. Therefore, findings in this aspect suggest that health and health care agency should look into these issues. Interesting findings related to this is that, data analysis have identified that health care professionals are very approachable therefore they should maintain this kind of trait when dealing with their patients. It is also essential for the health care professionals to know the patients cultural views before dealing with

them to avoid misinterpretation and mistreatment. However, some of the findings contradict results from the interviews. Hence that is the strength of using both quantitative and qualitative approach wherein data can be integrated and compared as discussed in chapter 6 (discussion chapter).

In the questionnaire, participants were asked about their personal profiles. These profiles were then used to analyse its relationship to their views and attitude as well as their access to health care services as shown in section 5.5 of this chapter. Findings show that among the 7 profiles that were served as the independent variables (age, educational level, length of stay, area of location, employment status, English language and combined household income) only four came out to have a significant effect on their health and wellbeing and on their access to health care services and that is their highest level of education, area of location of residence from the Philippines, English language and length of stay in rural Tasmania. Like other academic research that deals with migrants, English language and highest level of education is a popular barrier in the access of health care services. Thus data findings in this research are an addition to the existing literature. Intermarried Filipino women participants' claimed that they speak good English and they are highly educated (i.e., University/Tertiary graduate) however, in some ways it didn't help them because Australian English is different from their English. So findings recommend that migrants should learn basic Australian English.

# **Chapter 5 – Qualitative Data Analysis**

## **5.1. Introduction**

This chapter presents the qualitative data analysis results from the interviews. The results are presented according to the emerging themes identified in the analysis. The discussion of results seek to connect the literature review and the objectives of this study which focuses on health and wellbeing issues facing intermarried Filipino women in rural Tasmania and their access to health care services.

Prior to the presentation of results, the data collection and analysis process will be briefly reviewed. Then the social-demographic background of the participants will be presented to show its distinction and its significant implications on the data analysis results. The analysis results are presented in three major themes, namely: health and wellbeing issues; issues in accessing health care services; and coping behaviour. This chapter will conclude with a summary, highlighting the prevalent details rises from the analysis.

## **5.2. Data collection and analysis**

Chapter 3 discussed the data collection and analysis of this research in details. However, it is best to briefly recapitulate the process before presenting the data results. Data were gathered using semi-structured face-to-face interviews involving 15 intermarried Filipino women. The data were analysed using Grounded Theory Analysis (Punch, 2005) and Thematic Analysis (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006; Miller & Crabtree, 1992; Thomas & Harden, 2008) with the aid of NVivo version 8. Reasons for using both approaches are:

This study examines the views and attitudes of the intermarried Filipino women towards their health and wellbeing and their access to health care services. The two approaches are the most suitable approach for the analysis because the data were analysed inductively which “involves searching out the concepts behind the

actualities by looking for codes, then concepts and finally categories” (Allan, 2003, p. 1). These categories were then linked and the connections between concepts were examined which led to the emerging themes. These themes then formed the basis for presentation and discussion of the analysis.

- Data were coded inductively (grounded theory) to make sure that the raw data were coded transparently.
- The three steps of Grounded Theory Analysis facilitated in obtaining the emerging themes.
- To start with the data analysis using Grounded Theory Analysis, three steps were followed from Punch (2005, p. 205):
  - Find conceptual categories in the data;
  - Find relationship between categories; and
  - Conceptualise and account for the relationship at a higher level of abstraction.

These three steps imply three general types of codes such as: substantive codes, theoretical codes, and core codes. The first objective was to find the substantive codes in the data, wherein the categories generated from the empirical data but at a more abstract level than the data themselves. In this first level of analysis, some of these substantive codes appeared as more central in the data than others. The second objective was to bring the main substantive codes together to interconnect codes using theoretical codes. The third objective was to find the higher order or more abstract construct, the core category, which integrates into a theory which describes and explains them (Punch, 2005). To achieve these objectives, the coding process of the interview data involves: open coding (free nodes); axial coding (tree nodes); and selective coding (case nodes). The coding process was not necessarily conducted sequentially because they are more than likely overlapping and conducted concurrently. However, they are conceptually distinct operations. Therefore open coding finds the substantive codes; axial coding uses theoretical

codes to interconnect the main substantive codes; and selective coding isolates and elaborates the higher order core category (Punch, 2005). (See the table below for the coding themes and sub-themes.

Like Grounded Theory Analysis, Thematic Analysis also has three stages of data analysis:

- Deciding on sampling and design issues;
- Developing themes and codes; and
- Validating and using codes.

However, since this study uses both approaches in particular, stage two which is Developing Themes and Codes of Thematic Analysis, this was applied in the analysis process and integrated to the Grounded Theory Analysis. Stage two has three ways of developing a thematic code and these are:

- Theory driven;
- Prior data or prior research driven; and
- Inductive or data driven.

The three ways of Thematic analysis coding were used because they contribute to the development of a valid and reliable outcome. According to Boyatzis (1998), all these three ways move to developing themes, and the codes move the researcher toward theory development. However, “they differ in the degree to which the thematic analysis starts: a theory or the raw information” (Boyatzis, 1998, p. 29). Boyatzis (1998) further explains that “the concepts and models being discovered and built are subject to change during the process of inquiry” (p. 31). Thus it shows the importance of using the three ways in this study.

The advantages of integrating Thematic Analysis and Grounded Theory Analysis are:



- Thematic Analysis is used to process, analyse, and interpret information; it allows a more comprehensive understanding of the phenomenon.
- It enables researchers to use a wide variety of information in a systematic manner that increases accuracy or sensitivity in understanding and interpreting observations about the people, events, situations and organisation.
- It also facilitates the researcher to access a wide variety of phenomenological information as an inductive beginning of the inquiry, especially during the pre-discovery stage. (Boyatzis, 1998; Miller & Crabtree, 1992).

### **5.3. Data analysis process**

This section covers the data analysis process from initial to final coding. Each coding categories shows connections and relationships from one to another. These coding processes are important to illustrate the emergence of the key themes and sub-themes which form the basis of data analysis results presentation.

The first step of coding: Initial or open coding (free nodes)

1. First year in Tasmania
2. Cultural differences (Tasmania and country of origin)
3. Adaptation to the new culture
4. Traditional views about health
5. Personal perception of being healthy
6. The effects of traditional views in a new cultural environment
7. Importance of health & wellbeing (H&W) in a new cultural environment
8. Major issues affecting your health and wellbeing

9. Coping with H & W issues
10. Expectations of health care services (HCS) (before and after migration)
11. First access to health care services
12. Persons who assisted you in accessing HCS
13. Importance of social networking to your H & W
14. In-laws' role in helping you accessing HCS
15. Filipino community's role to promote H & W
16. Have agreed to support family back home
17. Effects of sending money to the family back home
18. Effects of age gap as a couple
19. Effects of having the same/different religion as a couple

The list of themes listed in the first coding process show the results of open coding from the raw data. The codes appeared to contain more abstract themes than the data themselves. However as the coding continues, key themes and sub-themes emerges as shown in Table 5.1.

Table 5-1 *Axial coding (Tree nodes)*

| Themes                          | Sub-themes  |
|---------------------------------|---|
| 1.) Health and wellbeing issues | <ul style="list-style-type: none"> <li>– Personal perception of health</li> <li>– Traditional views about health</li> <li>– Effects of traditional views on health and wellbeing</li> <li>– Importance of health and wellbeing in a new cultural environment</li> <li>– Major issues affecting health</li> <li>– Handling the issues <ul style="list-style-type: none"> <li>- Awareness</li> <li>- Acceptance</li> <li>- Social networking</li> <li>- Faith and religion</li> </ul> </li> </ul> |

|                                    |  |
|------------------------------------|--|
| 2.) Access to health care services | <ul style="list-style-type: none"> <li>– Personal expectations of health care services in Australia</li> <li>– First experience accessing health care services</li> <li>– Persons who assisted you to access the services</li> </ul>   |
| 3.) Social networking              | <ul style="list-style-type: none"> <li>– Importance of social networking to your health and wellbeing</li> <li>– In-laws (husband's family)</li> <li>– Filipino community</li> </ul>   |
| 4.) Personal challenges            | <ul style="list-style-type: none"> <li>– Age gap</li> <li>– Religion</li> <li>– Supporting family back home</li> </ul>   |
| 5.) Experiences                    | <ul style="list-style-type: none"> <li>– Access to health care services</li> <li>– As a migrant in general</li> <li>– First year in Tasmania <ul style="list-style-type: none"> <li>- Cultural differences from the place of origin</li> <li>- Adaptation and acculturation</li> </ul> </li> </ul> |

Table 5-1 presents the axial coding (tree nodes) process resulted from open coding. In this section of the coding process, themes and sub-themes emerged to interconnect the data that has been coded and identified.

The third coding process is selective coding in which a thorough reading and re-reading of analysis and the coding results leads to a higher order or more abstract construct of themes. These results became the main emphasis for the presentation and discussion of findings, as shown in Table 5-2. In this Table, three main themes are identified (i.e., health and wellbeing issues, issues in accessing health care services, and coping behaviour) with their corresponding sub-themes and sub-sub-themes.

Table 5-2 *Selective coding (Case nodes) Outline of the hierarchical order of key themes, sub-themes and sub-sub-themes*

| Themes                                       | Sub-themes   | Sub-sub-themes   |
|--|--|--|
| 1.) Health and wellbeing issues              | – Cultural issues  | <ul style="list-style-type: none"> <li>- Personal and traditional views on health</li> <li>- Cultural adjustment</li> <li>- Stress and depression</li> <li>- Eating habits and food</li> </ul>                                       |
|  | – Migration issues   | <ul style="list-style-type: none"> <li>- Identity, self-concept and new social role</li> <li>- Loneliness and homesickness (i.e. absence of family and friends)</li> </ul>   |
|  | – Social issues  | <ul style="list-style-type: none"> <li>- Sense of belonging</li> <li>- Social support or networking</li> <li>- lifestyle</li> </ul>  |
|  | – Marital issues   | <ul style="list-style-type: none"> <li>- Age gap</li> <li>- Expectations and disappointments</li> <li>- Finances and supporting family back home</li> </ul>  |
| 2.) Issues in accessing health care services | – Personal expectations of health care services  | <ul style="list-style-type: none"> <li>- Before migration</li> <li>- After migration</li> </ul>  |
|  | – Barriers in accessing health care services   | <ul style="list-style-type: none"> <li>- Language difficulty (leads to the lack of knowledge about available resources and over dependence on the husband)</li> <li>- Health programs (traditional beliefs and practices)</li> </ul> |
| 3.) Coping behaviour                         | <ul style="list-style-type: none"> <li>– Awareness</li> <li>– Acceptance</li> <li>– Social networking</li> <li>– Faith and religion</li> </ul> |  |

#### 5.4. Social-demographic background of the participants

Fifteen intermarried Filipino women participated in the face-to-face semi-structured interviews. The participants' demographic background such as age, educational level, year of arrival in Australia, area of location from the Philippines, and the age gap between them and their Australian husbands were obtained during the interviews. The main reason for getting this type of information is to examine if there is any association between their demographic backgrounds and their views on health and wellbeing issues in a new cultural environment (recent residence).

Table 5-3 *Social-demographic background of the participants*

|  | Number of participants<br>(N) | Percentage<br>(%) |
|--|-------------------------------|-------------------|
| <b>Age groups</b>                                    |                               |                   |
| 25 – 35 years of age                                 | 3                             | 19.98             |
| 36 – 45 years of age                                 | 9                             | 59.94             |
| 46 – 55 years of age                                 | 3                             | 19.98             |
| <b>Length of stay in Australia</b>                   |                               |                   |
| 6-10 years   | 5                             | 33.3              |
| Over 10 years  | 10                            | 66.6              |
| <b>Areas in the Philippines where they come from</b> |                               |                   |
| Rural  | 10                            | 66.6              |
| Urban  | 5                             | 33.3              |
| <b>Age gap</b>                                       |                               |                   |
| 1-5 years  | 4                             | 26.64             |
| 6-10 years   | 4                             | 26.64             |
| 11-15 years  | 2                             | 13.32             |
| 16-20 years  | 3                             | 19.98             |
| 21-25 years  | 1                             | 6.66              |
| 26-30 years  | 1                             | 6.66              |

Table 5-3 shows that most participants were in the age-group of 36-45 years (59.94%). While 10 (66.6%) of the participants have lived in Tasmania for over 10 years. In addition, 10 (66.6%) participants came from rural areas of the Philippines. With regard to the age gap between the participant and her Australian husband, four (26.64%) fell into the bracket of 1-5 years and the same number of participants for 6-10 years, while three (19.98%) had an age difference of 16-20 years.

## 5.5. Data analysis results with the emerging themes

The analysis reveals three main issues (as shown in Table 5-2) facing intermarried Filipino women namely: health and wellbeing issues; access to health care services; and coping strategies. These issues respond to the research questions and the literature review of this study.

### 5.5.1. Health and wellbeing issues

Holistically speaking, “health is the wellbeing of the whole person and therefore not just a fit body, but a well mind and spirit” (Coward, 1993, p. 94). However, good

health depends on a person's outlook in life. According to the Monash City Council (2007),

*...health and wellbeing is determined by factors other than an individual's genetics and biology. It recognises that factors such as access to health services and facilities, job security, opportunities to engage in a safe and attractive physical environment and community events, and the availability of clean air, food and water, combine to support individuals in their quest for maximum health and wellbeing. (2007para. 3)*

This statement has complemented the factors found in the data analysis as it clearly explains that health and wellbeing is affected by both environmental and cultural factors. Below are the factors identified from the data analysis results:

#### **5.5.1.1. Cultural issues**

Culture is shaped by values, beliefs, norms, and practices that are shaped by members of the same cultural group. Culture also guides a person's thinking, behaviour, and being and becomes patterned expressions of who they are. In fact this pattern of expression is passed from generation to generation (Giger & Davidhizar, 2004). Intermarried Filipino women have brought with them their own culture which has become an obstacle for their acculturation to the host culture and has affected their health and wellbeing. As Courtright (2005) explains, immigrants often possess a distinguishing package of characteristics that set them off from more established local populations, including language, ethnicity, culture, income, type of job and possibly even education and legal status. Cultural beliefs and practices strongly influence peoples' health; culture is by no means the only factor involved as culture is always heterogeneous and is never static (Hardon et al., 2001). The data analysis results have identified that personal and traditional views on health, stress and depression, climate adjustment, and eating habits and food are the most common problems facing intermarried Filipino women.

#### 5.5.1.1.1. *Personal and traditional views on health*

Intermarried Filipino women's views on health and wellbeing are very different from their Australian husbands. Intermarried Filipino women view health as the absence of diseases. They described being healthy as: being energetic which means the body and mind are very productive; being happy, which means content in their life choices; and lastly eating healthy food and exercising regularly. These descriptions from the participants summarise that health for them is being free from diseases and that their mind and body can function well.

*Being healthy means you don't have any illness, and that you are happy and contented. Have a healthy diet, healthy food and exercise regularly, and that your body and mind can function well. (Participant 13)*

However traditionally, intermarried Filipino women have cultural practices and beliefs which were inherited from different ethnic groups who settled in their homeland in the past. Ethnic groups included the Chinese, East Indian, Arab, Spaniards and American (Lassiter, 1995). Some of the most common traditional Filipino beliefs and practices are: Heating and cooling relate to quality and balance of air (*hangin*, "winds") in the body. Cold drinks or cooling food should be avoided in the morning because they are believed to cause abdominal pain (*masisikmura*). Overeating late at night is a form of food imbalance. Filipinos believe it can cause sudden abdominal cramps (*bangungut*) that lead to death (Spector, 2004). As such, the data analysis provides additional information about various health beliefs and practices of the intermarried Filipino women. In their belief, being sick is: not allowed to take shower – as having a shower makes the body condition weaker; not allowed to lift heavy stuff – lifting heavy stuffs will strain the muscle; no cold drinks – cold drinks affects the body temperature; to take herbal medicine – herbs are better than biomedicine and see an *Albularyo* (witch doctor) for cure; and to pray – pray for help and forgiveness and you shall be cured. These results come from the participants who lived in rural and urban areas in the Philippines. Therefore, the area of location is not a significant factor influencing intermarried Filipino women's views and concepts about their health and wellbeing. Rather, the significant factor here is their views and beliefs. Studies regarding Filipino women in the United

States by Giger and Davidhizar (2004) and Lassiter (1995) shows that traditional Filipino health beliefs and practices have affected the health and wellbeing of Filipino women as well as their acculturation.

*Coming from the rural part of the Philippines, I grew up in the traditional way. Traditional lifestyle and lots of traditional or superstitious beliefs on what is good and what is not good. For example, when I am sick, I am not allowed to have a shower or do anything around the house or else I will get bughat, straining of the muscle. (Participant 13)*

One participant also added:

*When I am sick I am not allowed to take a shower, to drink cold water or to have cold food because these will affect my tummy. For our babies, we are not allowed to bathe them on Tuesdays and Fridays and no cutting of finger nails on the same days. The rest of the weeks are okay. (Participant 1)*

In contradiction to the above statements, Participant 11 expressed her views:

*No traditional views. I prefer to go straight to the doctor. I don't really have traditional views but I do believe that it is really up to me or what lifestyle will I have in order for me to have a good health. (Participant11)*

#### **5.5.1.1.2. Cultural adjustment**

Acculturating to the host culture often causes a great deal of unease and frustration because of the differences in the Filipino and Australian cultures particularly in the personal and traditional beliefs of the intermarried Filipino women. They were stressed and depressed because they felt that there was something missing and that things around them were not the same. They missed their family and friends and the loss of familiar faces and places played a significant role. Also, Tasmania's climate, which contrasts, also added to the changes they had to meet, considerably from the Philippines. Intermarried Filipino women coming from a tropical country found it hard to adjust to the cold particularly during winter months. As explained



earlier, Filipino women have their own concept of hot and cold. Their body has difficulty adjusting to the cold weather.

*I will never get acclimatised, I think. I have been here for over 10 years but am still suffering the cold during winter months. When I first moved to Tasmania, I had runny nose, bleeding nose, and hay fever which were so rare for me when I was in the Philippines. (Participant 10)*

#### 5.5.1.1.3. Stress and depression

Interaction with mainstream Australians and their culture is another reason that leads to stressful experiences of the intermarried Filipino women. The stress that they were experiencing is known as acculturative stress. As Schmitz (2003) points out, migrants encounter acculturative stress when they are “confronted with a variety of problems, such as maintenance or change of their own cultural identity, and dealing with conflicts between different systems of values, beliefs, and behaviour, namely those of the mainstream society, those of their own ethnic groups, and those belonging to their own personal spheres” (p. 1). However, Carballo and Nerukar (2001) explain, “whether migration is planned or not, voluntary or forced, some degree of stress is always involved” (p. 558).

It affects me in many ways because I am adjusting to the new culture and it is sad. As much as I want to retain my beliefs and practices, it doesn't seem right. I am confused and stressed. I don't know why culture varies so much. (Participant 1)

Aside from cultural factors, the participants stated other reason that causes stress:

*I am stressed and pressured because there is no family around and looking after my first baby daughter was hard. This was the time when I needed emotional support and guidance from my Mama. (Participant 2)*

*Rumours from my fellow friends and misunderstanding between me and my husband had given me a lot of stress. It was really disturbing. (Participant 8)*

Some of the key cultural differences identified by the intermarried Filipino women that contributed to the stress they were facing in the new cultural environment are as follows:

- Manner of people: Mainstream Australians are more liberated and much Westernised.
- Cultural beliefs: Mainstream Australians do not have strong cultural beliefs. They celebrate traditional celebrations like Christmas, New Year and birthdays commercially but not spiritually.
- Food: Australians are very particular about their food as most of them are health conscious.
- Climate: Tasmanian weather is unpredictable. Most of the time it is cold and some participants claimed that they would never get used to it.
- Relationship with family: There are no close family ties. They do not use familial honorifics to address family members who are older than them like: auntie, uncle, grandma and grandpa.

#### *5.5.1.1.4. Eating habits and food*

Eating habits and food preferences are among the cultural issues identified from the analysis. Intermarried Filipino women expressed that during the early years of their migration, they noticed that their eating habits had changed due to the absence of favourite and familiar Filipino dishes. Filipino women believe that food is the main source of health. Therefore the absence of Filipino food poses a challenge to them. They had to adjust their diet to maintain proper nutrition.

*Here in Australia, they have great food. But of course Filipino food is still different (iba pa rin ang lutong pinoy, kumbaga). Everything is really fresh especially seafood. (Participant 1)*

One participant added:

*I am happy here in Tasmania now, but my first few years was a bit hard. I tried to adjust to the weather, culture and food as my husband and his family love vegetables and salad. Every time we have a get together, I'm sort of looking forward to it but at the same time not because I know I will be eating fresh green salad and vegetables. It's just not like me. (Participant 6)*

Data findings show that husbands of these intermarried Filipino women are health conscious. They prefer more nutritious food such as vegetables and green salad. Thus it was difficult for the intermarried Filipino women initially because they are not used to such a diet. They tried to adopt to it at the beginning because as a wife they feel that they have to respect their husband's preference for food. However, later on they found that the change in diet affected their health because they were not eating the right amount of food that they are supposed to take, even though the food is good for the body.

*It is hard to get used to eat healthy food – I mean purely vegetables and salad. I can't live without rice. I miss the traditional Filipino dishes. Sometimes I bought Filipino ingredients from the Asian shops and cooked them but then it did not taste the same. (Participant 5)*

Most intermarried Filipino women find this problem with food more difficult to deal with when they are sick and during their pregnancy. Those are the times when they crave for their favourite Filipino dishes.

*During my pregnancy, I was longing to eat manggang hilaw (green mango) with salt and sugar. I was also craving for kinason (shell food) especially in soup, so yummy. But where could I find these here? Fish and seafood are frozen. They are not fresh and my doctor told me, they are not good for pregnant woman. (Participant 8)*

To some, the absence of popular Filipino dishes directed them to cuisines available in the host country which later on became one of their favourites.

*I love fruits and vegetables now, as well as fresh green salads. I'm glad that I have tried to eat them because if not I would have not known how yummy and good they are for my health. (Participant 5)*

The traditional food ingredients for the Filipinos include rice, fish, and vegetables (Giger & Davidhizar, 2004; Lassiter, 1995). For intermarried Filipino women in Tasmania, their typical dishes are: *adobong manok* (Fried chicken), *nilaga* (boiled dish like pork, chicken or beef with vegetables) and *pancit* (stir fried noodles). The main food every participant looks forward to eating are rice and fish. This is a very significant finding as rice and fish are the most common food for Filipinos. This is what they call dish and viand.

The cultural issues identified in this study show that “culture conflict is a common and serious problem in migration. It affects people in different ways, some more overtly than others” (Carballo & Nerukar, 2001, p. 560). These cultural issues have a bigger impact on the migration process of the intermarried Filipino women, as they change their so-called social identity (as explained in the migration issues section below).

#### **5.5.1.2. Migration issues**

Migration is historically defined as the process by which different ethnic, cultural, language, religious and groups have come into contact and thus presented both migrants and host communities with many challenges (Hugo, 2005). However Carballo and Nerukar (2001), explain migration in a simpler way as, living in a new place with the absence of family and friends, losing well established social networks, leaving traditional routines as well value system, which also mean having to adapt to a new social and psychosocial environments. This definition best describes the experiences of the intermarried Filipino women, as they have encountered difficulty in establishing themselves in the host culture and most of all difficulty in settling in. Such issues are: identity, self-concept and new social role; expectation and disappointment; loneliness and homesickness; and loss of family and friends.

#### 5.5.1.2.1. *Identity, self-concept and new social role*

Migration issues affect intermarried Filipino women's self-esteem and confidence because they are in a totally different environment and culture. Their identity, self-concept and social role have changed as a result of migration. The data analysis results review that intermarried Filipino women lose their identity and self-concept during their first three years of migration due to confusion arising from cultural differences. They do not know exactly how they should act in a manner that they will not be misinterpreted by their husbands and/or mainstream Australians. They lose their identity in a sense that they hesitate to or cannot act the way they have wanted to.

*Even at home with my husband, I can't be at home. Actually, it is not about my husband, it is about how I feel which I can't understand because the fact is that my husband loves me very much and gives me support. (Participant 5)*

This situation indicates that the intermarried Filipino woman was encountering self-disturbance, an experience most will share when they are in a different cultural environment. Other participants also emphasised:

*I don't know why, till this time I feel so uncomfortable to talk to my husband openly and show him my true feelings and emotions, especially when I am really upset and being misunderstood. (Participant S145)*

*I often laugh at myself and wonder why I need to ask for my husband's permission if I want something at home. Why can't I just do it like other wives do? They can easily do it without asking their husbands. Why do I feel this? (Participant S1)*

Losing one's identity is also losing self-concept. Physical, mental and emotional disturbance leads intermarried Filipino women to losing their confidence, trust, and their capability in completing tasks. Therefore they become dependent on their husbands. As a result, the participants had difficulty in acquiring and taking up their new social role in the host country which involves complex responsibilities. As a wife and as a mother, intermarried Filipino women experience this role differently.

They have different strategies in dealing with the new social status, however, most of them follow the typical role of a Filipino wife and mother which is being loving, caring, devoted and committed. There are still situations when they feel like giving up. As they mentioned,

*Here in Australia we have to do everything. We are not only a wife and a mother but also a worker, helper, financier, etc. We act like a robot which is very hard on our part. In the Philippines, we always have our families supporting and helping us in any way. (Participant 4)*

*I used to do all the household chores at home (Philippines) but here in Tasmania, it is a different situation because apart from performing all the chores, I have to work and at the same time look after my kids. It is so stressful. Sometimes I can't understand myself, and I am angry. (Participant 2)*

In the Philippines, regardless being rich or poor, it is easy for a woman to get a helper or a Nanny because labour is cheap. Sometimes the helper could be a cousin or a relative who needs to earn a living. However, in Tasmania, labour costs are very expensive.

Findings have shown that although intermarried Filipino women are now living in their new home country, their role as a daughter to their parents has never changed. Their responsibility becomes bigger, in a sense that they feel that they are obliged to support their family financially since they are living outside the Philippines. This situation is common as the daughter feels that she has to send some sort of support particularly financially as compensation, because her absence in some ways causes loneliness to their parents. Other reason is that their parents are expecting the financial support.

*When I was in the Philippines, all my salary went straight to my parents. Now that I am here in Australia even though my parents will not ask me personally, I know in my heart that they are expecting it as it is part of our culture to help and support our family financially. (Participant 4)*

#### **5.5.1.2.2. Loneliness and homesickness**

Feeling of loneliness and homesickness are other common migration issues, which is caused by the absence of family and friends. Filipinos are very well known for their close family ties and now that they are far away from their families, their absence leaves emptiness in their lives.

*I speak to my family once in a while online through yahoo messenger and I even get to see them via webcam but it is still not enough. Iba pa rin yong maka-usap mo sila sa personal at mahawakan. (Participant 14)*

Aside from migration issues, intermarried Filipino women also encounter social issues that affect their health and wellbeing as well as their acculturation to the host country.

#### **5.5.1.3. Social issues**

Social issues are matters which directly or indirectly affect many or all members of a society and are considered to be problems, controversies related to moral values, or both (n.a., 2009b) . They are technically referred to as factors affecting social wellbeing which means the appraisal of one's circumstance and functioning in the society (Shepard, 1979). They also include an individual's feelings towards society in which they live, their sense of belonging, as well as their contribution in the society. Most common social issues include: language barrier, cultural barrier, racism, lifestyle and social networking (Camacho, Australian Social Trends, 2008). From the data analysis of this research, three important social issues have been identified, namely: sense of belonging, social support and lifestyle.

##### **5.5.1.3.1. Sense of belonging**

Sense of belonging is an issue that many intermarried Filipino women faced during the early years of their settlement in the host cultural environment. They desire for a sense of belonging not only to the new community, but also at home with their husbands. Due to cultural differences, intermarried Filipino women have difficulty in making themselves at ease and comfortable in their new home.

*I am happy with my husband here in Tasmania but there are times I feel that I am so different from the people here. I don't value what they value and they don't value what I value. Even with my husband we have different outlooks in life and we have different ways of dealing with life's circumstances. (Participant 6)*

From the statement above, having a sense of belonging does not only entail being part of the community and feeling at home but also trying to act like mainstream Australians.

#### **5.5.1.3.2. Social networking**

Sense of belonging urges the intermarried Filipino women to find social support and networking. Social networking involves having a good relationship with the in-laws (husbands' family), networking with the neighbours, interacting with the Filipino community in rural Tasmania and maintaining the relationship with families in the Philippines. Research shows that an individual's social support network can have a substantial impact on successful social and community adjustment. Strong supportive ties among family members are considered especially important (Pink, 2008). Friendship may also contribute to an overall sense of belonging, increased levels of trust and sharing of information and introductions within a friendship network (Edwards, 2004).

*Friends are very important in my life here in Tasmania because there are things I cannot tell my family but it is easy with friends. My friends understand my situation here. Having good friends and being part of the Filipino community make me feel secured. (Participant 5)*

The importance of social support network also extends to the broader community (ACORN, 2003) a concept shared among the Filipinos. They have the so-called *Bayanihan* which means helping each other, anyone in the community. Thus the lack of social support in their new home results in stress and depression for the intermarried Filipino women.



#### 5.5.1.3.3. *Lifestyle*

Networking and sense of belonging also depend on the lifestyle of the intermarried Filipino women. Lifestyle is taken to mean a general way of living based on the interplay between living conditions in the wide sense and individual patterns of behaviour as determined by socio-cultural factors and personal characteristics (Health Education Unit, 1993). It is also based on the idea that people generally exhibit a recognisable pattern of behaviour in their everyday lives (Lyons & Langille, 2000). Thus, achieving a healthy lifestyle for the intermarried Filipino women is somewhat a challenge because the Australian lifestyle is different in many ways. Food preferences, diet, daily routines and socialisation in the neighbourhood are examples of these challenges. When these intermarried Filipino women were in the Philippines, they used to be happy for what they had, they ate what was on the table, they never tired of doing the same daily routines, and they daily had time to chat to their neighbours. While in their new home Tasmania, things have changed. In terms of food and diet, some of them have enjoyed the foods available so much to the extent that they have over indulged which results in overweight.

*My husband loves to cook and it's all very delicious. I never waste his cooked food. In fact, I always spare a plate for my midnight snacks. (Participant 4)*

*I don't know I just love it especially when I am depressed and lonely; I keep on eating and craving for more delicious food. (Participant 15)*

However, some of them have difficulty finding the food that they really like due to food taste and their health suffers for not obtaining proper nutrition.

*There are so many yummy looking foods here but I am so hesitant to taste them because I am concerned that it might affect my tummy. (Participant 7)*

Changes in daily routines and chatting with neighbours have significant impacts on the lifestyle. Basically their daily routines are similar to what they had before. The only difference is that they are on their own with no one else. Talking to the neighbours was part of their daily lives which enhanced their wellbeing because this

made them feel happy. Here in Tasmania, they cannot even see their neighbours. If they do, they have only simple greetings like “hello and how are you?”

*The way of life here is quite different. I miss the simple and everyday routines that I did at home. Talking to my neighbours and asking them about the latest happenings in the neighbourhood. The good thing at home is everyone knows each other. So it is very easy to identify if someone is new in the Barrio. Neighbours are also like our families because they are always there for us when we need them. (Participant 5)*

A healthy lifestyle is generally characterised as a balanced life in which one makes wise choices. However, the array of choices is influenced by many factors (e.g., regular routines of work, leisure, and social life) (Lyons & Langille, 2000).

All the issues discussed above (cultural issues, migration issues and social issues) are the leading factors that influence marriage. The participants of this study are the Filipino wives whom we referred to as intermarried Filipino women. Being married, some marital issues are found in the analysis.

#### **5.5.1.4. Marital issues**

According to Eve (2008), marital issues in interracial marriages are more complicated because each partner comes with a completely different set of rules such as daily habits, view points, and values. Eve (2008) further explains that each person has different ways of relating to others and thus, different strategies for negotiating differences. Deciding on whose rules to use can be complicated and could cause misunderstanding or conflicts, especially for two people who love each other. However Miller-deBerard (2006) indicates that the most common marital issues seen in the therapist’s offices include depression, anxiety, relationship dissatisfaction, finances, parenting issues and blended or extended family relationships. The data analysis from the interviews is consistent with Miller-deBerard’s findings. In addition, marital issues affecting intermarried Filipino women are: age gap, expectations and disappointments, finances and supporting family back home. Every issue they have encountered is sensitive because it would

affect their relationship, acculturation process, especially their health and wellbeing.

#### 5.5.1.4.1. Age gap

Age does matter in a relationship because the older the person and the more experience he/she has, the more settled and mature he/she is. According to Alati, Najman and Williams (2004), “Filipino brides are considerably younger than their partners” (p. 146), which also bears similarity to the intermarried Filipino women participants in this study (see Table 5.3 - Participants’ socio-demographic background – Age gap). In this case, Filipino women rely more on their husbands especially during the early years of their marriage since they “originated from a communalistic culture and society. It will not be easy for them to acculturate into the new environment. Thus this leads to a possible cause of distress and may effect on their mental wellbeing” (Alati, et al., 2004, p. 146).

Table 5-3 shows that most of the intermarried Filipino women participants are younger than their Australian husbands. Only one participant is 2 years older than her husband. However, it seems that age gap is never a problem for their relationship as husband and wife. It only grows into a problem when intermarried Filipino women become over dependent on their husbands which stops them from developing independence. In fact it is an advantage for younger Filipino wives since their husbands are mature and experienced to face life’s challenges to care for the family.

*It makes our relationship a lot better because my husband had a lot of experiences in life and he knows what’s best for our family. (Participant 8)*

*It affects us in a way of decision making. As a Filipina, I am taught to obey the eldest opinions. So I obey my husband but of course I try to explain my side as well. (Participant 1)*

In contrary, it is also an advantage for Filipino spouses who are older than their husbands. They feel superior and have a say in decision making.

*I have adjusted a little bit since I am older than my husband by 2 years. He also asks me when making a decision. He cannot decide by himself alone. It is also good in a way because I feel that I am a bit superior in some cases.*  
(Participant 11)

#### 5.5.1.4.2. *Expectations and disappointments*

Intermarried Filipino women come and live with their husbands in Australia with many expectations and priorities, like women from the Middle East, who have had high expectations before their migration to Australia due to the country's high standing on human rights issues (n.a., 2009b). Women from former Yugoslavia however stated that their expectations did not match their actual experiences in transit and on arrival to Australia (n.a., 2009b). Therefore expectations somewhat gives hope and courage to the intermarried Filipino women to migrate to Australia. These expectations come from their own perception about Australia as a land of opportunities. They have expected that their lives would be better economically and socially and there are more opportunities for them to grow further. They also expect to have good access to any services in Australia, particularly health care services. These expectations affect their mental health and wellbeing as most of their perceptions seem to contradict their actual life in rural Tasmania. Therefore their expectations sometimes can lead to disappointments.

*I expected to have a wonderful future here because I believed there were lots of opportunities available in Australia especially in terms of work. I cannot deny the fact that before coming here I expected to have a better future as everyone has dreamed of, I suppose.* (Participant 15)

Another participant said:

*This is not the life I had expected. I don't blame my husband but I blame the situations. The sad part is I have to keep it from my family back home as I don't want them to worry. It's hard because when I talk to them I have to pretend that I am happy even though I am not.* (Participant 2)

#### 5.5.1.4.3. *Finances and supporting family back home*

Disappointments affect greatly the mental and emotional wellbeing of the intermarried Filipino women. In addition to their responsibility as a wife to the husband and a mother to the children, they also have a responsibility to their family back home which is one of their priorities in life especially if one of their family members is sick. This kind of behaviour or practice affects the intermarried Filipino women emotionally as some husbands cannot understand why they need to support their families financially.

*Sending financial support to my family back home is often the beginning of our arguments as my husband wonders why we need to do it. But when I explain to him that the money I send is for the education of my younger brother and sisters and knowing that the money I send is from my own pocket, then the issue is resolved. (Participant 1)*

However, another participant stated:

*It will affect negatively if you hide it from them (husband) but if you are open enough and let them know what you are doing and why you need to do it, then there is no problem. My husband knows from the beginning that we have to help my family and he is happy to do it. (Participant 10)*

Another cause of disappointment is career pathway. Intermarried Filipino women with high educational achievements have accepted their domestic roles as devoted housewives in the initial stage of their intermarriage. However, they still hope for an appropriate job which suits their educational qualifications. Some of them extended their education qualifications by undertaking advanced courses at skill institutes and/or universities. There are cases that intermarried Filipino women's husbands provided full mental and financial support to them in order to enhance their academic achievements. However, there are also cases in which conflict has occurred between husbands and wives in access to education. The conflict could lead to depression and mental suffering due to lack of understanding and communication.

*I have a degree, but look at where I am now? If only I had known this is where I would end up, I should not have gone to a university and got a degree. (Participant 5)*

However, the situation of this participant is different from the one stated below:

*I am so thankful to my husband for letting me go to school and pursue my dreams. Now I am working and have my own money. (Participant 6)*

### **5.5.2. Issues in accessing health care services**

Health care services are the most important agency that helps to maintain people's health and wellbeing. However there are barriers affecting access to the services. The most common barriers identified in the literature are: language barrier, cultural differences, transportation difficulties, poverty, lack of health insurance, immigrant's status, limited availability of providers, scheduling appointments and long waiting period (Bischoff, Tonnerre, Eytan, Bernstein, & Loutan, 1999; Flores, 2006; Flores & Vega, 1998; Jenkins, Le, McPhee, Stewart, & Ha, 1999; Ngo-Metzger et al., 2007). Among these, cultural and language barriers are the two most renowned and have been constantly listed in the researchers' study results.

As one of the main focus areas of this research is the views and attitudes of the intermarried Filipino women towards their health and wellbeing, their expectation about health care services in Australia is given importance.

#### **5.5.2.1. Personal expectation of health care services (before and after migration)**

Before coming to Tasmania, intermarried Filipino women's expectations and views about the health care services were high in terms of resources, medical equipment, health care professionals, and the services itself compared to their country of origin. These expectations continue after migration.

*I expect that Australian health care services are a lot better than those in the country I come from and especially the service from the doctors, nurses and other health care professionals. (Participant 3)*

*I learned from school before that countries like USA, Australia and China had very good health care services. So I have expected that Australian health care services are as good as USA but I was wrong because Australian health care services are much better than USA. (Participant 5)*

However there are factors that affect their accessibility to the services as will be discussed in the next section.

#### **5.5.2.2. Barriers of accessing health care services**

Data results show that the barriers affecting intermarried Filipino women are: language barrier, traditional beliefs and practices, lack of knowledge about the available services, transportation, length of stay, and over dependence on the husband.

##### **5.5.2.2.1. Language barrier**

Language is at the core of communication. Therefore it is a hindrance for accessing health services when a migrant cannot speak the language of the host country. In the case of the intermarried Filipino women in this study, they pointed out that to speak the language (English) was not so much of a problem. However, the accent, pronunciation and the colloquialisms used by local Australians made it hard for them to comprehend.

*I have been living in Sydney and Tasmania for many years but I still find it difficult to fully understand other Australians, even my husband especially when he talks really fast. I even attended a school in Sydney and got a chance to mingle with other Australians. However, I'm still not used to their accent. (Participant 6)*

Data shows that during the early stage of migration to Tasmania, when these intermarried Filipino women needed to contact the doctors or anyone, they asked their husbands to do it for them. It is because they were apprehensive that they might not be understood by the person whom they were going to talk to or the other way round. This led to over dependence on the husband. They rely more on

their husband and they do not access the services without them. This problem exacerbates as their husbands are not always home. Intermarried Filipino women, who cannot drive, find this situation extremely difficult especially when they are sick and need to consult a doctor. Lack of knowledge about the available health services also contributes to the issues of not getting the right services. Due to over dependence on their husbands, intermarried Filipino women do not make enough effort to find information about the different services available in the host country.

*At first, I let my husband make an appointment for me to see our family doctor because I was so hesitant to make a call to the medical centre. In fact during my first pregnancy, every time I had a check-up, we made it a point that my husband would be available on the day I had the check-up.*

(Participant 5)

*I have heard from my friends about different health care services but I did not take it in because I know my husband knows where we need to go and I leave it all up to him.* (Participant 1)

#### 5.5.2.2.2. *Traditional Filipino beliefs and practices*

Traditional Filipino beliefs and practices also hinder intermarried Filipino women's access to the health services, particularly for those who come from the rural areas in the Philippines where they have a strong practice of traditional medicine and beliefs. They find it hard to adopt the new health program available in the host country. As mentioned in Table 5-3, 10 of the intermarried Filipino women come from rural areas. One of them mentioned that "the practices they have had have been part of their lives since birth" (Participant 13). Thus, accepting and adopting the new health practices affect their way to maintain health and wellbeing.

*It was quite hard at first because I am shy and I felt so hesitant to approach the doctors or any health care professionals or ask questions. There was a time that I wasn't treated well. I don't know if it was because of racism or because I was only quiet and not expressing myself.* (Participant 14)



*If I am sick I would rather observe my condition first before consulting a doctor as I am not used to it. As long as I drink a lot of water and have some rest, I should be fine. If I am in the Philippines, then I will easily get some herbal medicine. (Participant 3)*

Confronted with different health and wellbeing issues, intermarried Filipino women have learned to develop coping strategies as they go on with their journeys in interracial marriages.

### **5.5.3. Coping behaviour**

This section reveals the different behavioural strategies used by intermarried Filipino women in coping with the different issues they have experienced and how these strategies come about. Coping skills or behaviour refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health (Lyons & Langille, 2000). They are the skills people use to interact effectively with the world around them, to deal with the events, challenges and stress they encounter in their day to day lives. Effective coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. Coping behaviours help people deal with the challenges and stress in life without recourse to risk behaviours (Lyons & Langille, 2000). The following coping behaviours that drive the intermarried Filipino women when dealing with all the issues they have encountered are: awareness, acceptance, social networking and faith.

#### **5.5.3.1. Awareness**

Living in a place where everything is different from what they have been used to, takes considerable effort and courage to face life day by day. According to Hassed (2008), living without awareness is a little like living in a dark room, where people cannot see or understand what is in front of them and cannot move purposely. It is also the case for intermarried Filipino women who are conscious about the new cultural environment, their new homes with husbands, the people and the community around them, the ways of transportation, and access to services,

lifestyle and most of all the changes within themselves. Being unaware, they have realised that it would be helpful for them to know more about Australia in general so that they will understand the culture and lifestyle of their host country. The findings show that in order for the intermarried Filipino women to learn Australian culture, they watched Australian shows, listened to the news, visited historical places, and read magazines and books about Australian lifestyle. This “cultural awareness” recognises that we are all shaped by our cultural background, which influences our interpretation of the world around us, and perception of ourselves in relation to other people. Awareness of cultural practices will also help increase cultural knowledge by providing an overview of cultural characteristics and issues (n.a., 2006a).

*I try to get some information about Tasmanian lifestyle, watch news and read newspapers as often as I can. (Participant 1)*

*Join a club and go to church, meet new people. Inquire about the different places to know where it is and get familiarised with it. In fact my husband tours me around Tasmania so I can see its beautiful heritage. (Participant 10)*

*I talk to my husband. I ask him about their culture so that I can understand it and am able to adjust to and adopt it later on. (Participant 12)*

However, intermarried Filipino women have different ways of acquiring information as each of them has different needs and preferences. In today’s world in which almost everything was run by a machine or technology, there is no doubt that telephone and internet are among the most common ways of getting information. Intermarried Filipino women access the internet not only for general information but also to talk and see their family back home to ease their homesickness and loneliness, since online chatting and webcam are so popular nowadays. Migrants these days are very lucky in terms of access to technology because wherever they are, even in very remote areas they can still access the internet as long as they have a connection. As long as they know how to use the internet, they can do many things online.

*I love surfing on the net. In fact when there is something that I really want to find out, for example certain news that I missed or anything about health and lifestyle, I just type the keywords in the search box. Then I get a lot of relevant articles which is so amazing. (Participant 5)*

Other participants also inquire information through their network of friends:

*At first, aside from my husband, I always turn to my friends for any information because they have been here for a while and I believe they know more about the ins and outs of the community. (Participant 7)*

Awareness will not be complete without acceptance and living with it. Intermarried Filipino women find out that life in the new home will become easier if they learn to accept and adopt its culture and lifestyle.

#### **5.5.3.2. Acceptance**

To successfully settle in a new place which has totally different culture, norms and tradition requires ready disposition to accept changes. It is not easy to accept certain changes rather it will happen gradually over time as migrants continue to live and adjust to their new “called-home”. Accepting a new culture also requires the acceptance of one’s self. Like acceptance of changes in daily routines, lifestyle and the cultural environment. According to Shepard (1979), self-acceptance refers to an individual's satisfaction or happiness with himself/herself, and is thought to be necessary for good mental health. Shepard (1979) further describes that self-acceptance involves self-understanding, a realistic, albeit subjective, awareness of one's strengths and weaknesses which results in an individual's feeling about himself/herself that he/she is of unique worth. However Hautman (2005) points out that acceptance allows change and its mode includes everything, even judgement. It also allows individuals to feel good even before reaching their goals. When individuals learn to accept what they have before them whether they are good or bad, it shows the beginning of a new life with new possibilities.

*I try to adjust and accept my way of life here because I am married with an Australian and this is now my life. (Participant 7)*

*Later on I'll get used to it. I tell myself that this is my home now so I have to learn to accept it. I believe that the more I engage myself with my new life now, the easier it gets. (Participant 8)*

These are common behaviours shown by intermarried Filipino women. They believe that certain things happen for a reason and there is always an explanation as to why it has happened. It is not unusual for them to accept what is happening in their new life. Consequently their ways of acceptance vary which reflect their personality. The remarks above from the intermarried Filipino women have indicated self-realisation which has granted them the wisdom of acceptance. In contrast, other intermarried Filipino women have naturally accepted their new life in in their new home.

*I just go with the flow. I live everyday as normal. For me that was the easiest thing to do than trying to figure out things which will make you wonder more and worry. I know there are some differences in terms of lifestyle but I do not let that affect me. (Participant 14)*

*I have adjusted myself to be flexible in all things around me. I guess I was expecting that life would be different here. (Participant 9)*

Intermarried Filipino women also learn to accept illness as a natural common phenomenon especially with the cold weather in rural Tasmania. Intermarried Filipino women most of the time experience cold and flu as their bodies are still adjusting to the cold weather. All the participants in this study commented that they would never get used to the weather. Some of them have been living in Tasmania for more than 10 years but are still not acclimatised.

#### **5.5.3.3. Social networking**

One of the most important factors promoting wellbeing is an individual's personal relationship (Shah & Marks, 2004) which involves relationship with the spouse, family members, friends and people in the community. Social networking plays a significant role in the life of the intermarried Filipino women. Through networking, they have learned to extend their connections in the community and meet fellow Filipinos and other people who have now become their good friends.

*The Filipino community is very helpful and almost all of members become my good friends. We share the same feelings and experiences. The only thing is in making friends you have to make sure that you know the person well before you give your full trust. (Participant 14)*

Strong social networking with others enables migrants to cope with new challenges (Courtright, 2004). People need supportive, positive relationship and social belonging to sustain wellbeing (Ashcroft & Lynas, 2008). Therefore, social networking plays an important role in the life of intermarried Filipino women in rural Tasmania. Filipino women are strongly family-orientated in the sense that family members support one another mentally, emotionally and financially regardless of age, gender and social status. Thus while these Filipino women are living with their children and husbands in Australia, they still want to maintain a strong family tie with their families in the Philippines. Support from families and friends and communities help them solve problems, deal with adversity and maintain a sense of mastery and control over their life circumstances (Smith, 2004). As WHO says, “mutual trust and respect in the community protect people and their health” (Smith, 2004, p. 71).

*My fellow Filipinos serve as my family here. They make me feel at ease and helped me settled well here. When I am with them I feel so happy and laugh out loud. I can be myself. They also help me realise that life will be more meaningful if we face and tackle all our problems instead of just sitting down and doing nothing. (Participant 13)*

However, some intermarried Filipino women were hesitant to mingle and connect with their fellow Filipinos because of the worries for rumours. This situation is given importance in this research because this is part of the data findings and it is significant to show both positive and negative results of the analysis.

*Because of what I have experienced, I am hesitant to mingle with my fellow Filipinos unless I know these persons well. Some make rumours and I don't like that. In my opinion, we should help each other as Fellow Filipinos and not be back-biting each other. Sometimes it is also best to mingle with*

*Australians and make friends with them because they are nice people and sincere as well. (Participant 7)*

#### **5.5.3.4. Faith and religion**

The Philippines is a catholic country and Filipinos are pious believers' especially Filipino women. Intermarried Filipino women believe in the power of prayers and faith. At times of trouble, distress, and in any kind of difficulties, they pray and believe that everything will be alright. It may be hard for others to understand why these Filipino women have this kind of faith and why this will help them.

*I believe that God is there for us so there is no need for me to be scared. I leave everything with him. And I always believe that things happen for a reason and that reason is to prepare me for life's challenges. (Participant 1)*

Responses indicate that the absence of family and friends from the Philippines and facing cultural pressures make them lean on their faith and bringing them closer to their creator. However, some participants pointed out that they were not able to perform their Christian rituals as often as they wanted but their faith remained strong.

*Being away from my family makes my faith stronger and I keep on praying for their safety and good health. (Participant 6)*

### **5.6. Conclusion**

The utmost advantage of analysing qualitative data is the totality of its process as it allows the researchers to discover and uncover the underlying meanings, patterns and themes from the raw data. This chapter has presented the researcher's interpretation of the participants' insights from the raw data and its findings which were guided through the Grounded Theory analysis and Thematic Analysis.

Data findings reveal three main themes with corresponding sub-themes, namely:

1. Health and wellbeing issues – which include: cultural issues, migration issues, social issues and marital issues. These are the factors that have a

significant impact on the lives of intermarried Filipino women as they affect them physically, mentally, emotionally and spiritually.

2. Issues in accessing the health care services – which include personal expectation of health care services and barriers to accessing health care services such as: language barrier, traditional beliefs and practices, lack of knowledge about the available services, transportation, length of stay, and over dependence on the husband. These are the factors that hinder intermarried Filipino women's pursuit of better health and wellbeing.
3. Coping behaviour – which includes awareness, acceptance, social networking and faith/religion. These are the coping strategies identified from the analysis that have contributed to the adaptation and settlement of the intermarried Filipino women in their new home. Because of the coping behaviour, they are able to adjust and learn to live comfortably again.

The findings clearly show that health and wellbeing issues are the area of highest concern among intermarried Filipino women. For instance, to consult the best doctors, nurses or health care professionals and attend the best health care services in the world do not constitute all one would need to improve health and wellbeing. The factors that shape health and wellbeing are the ones that affect society as a whole (Lloyd, et al., 2004). It is the culture, norms and tradition of one's society. Culture includes all aspects of society, to describe an entire way of life of a people (Eckersley, 2001). Therefore for the intermarried Filipino women, health and wellbeing is as precious as the country's economy, which needs to be nurtured in order to keep them free from illness and giving them a happy life.

# **Chapter 6 – Discussion and Interpretation of Data Findings**

## **6.1. Introduction**

In Chapters 4 and 5, the results of data analysis have been presented statistically and narratively indicating how the results answer each research objective detailed in Chapter 3 (Methodology Chapter). This chapter seeks a deeper explanation by interpreting the integrated data findings from both quantitative and qualitative approaches. The interpretation of the integrated data findings will be discussed in conjunction with the four research objectives: (1) to identify the acculturation problems facing intermarried Filipino women in rural and regional Tasmania; (2) to understand the health concepts held by intermarried Filipino women and to examine the views of intermarried Filipino women about their health and health care in rural and regional Tasmania; (3), to identify the problems facing intermarried Filipino women in accessing health care services in rural and regional Tasmania; and (4), to identify the social and cultural capitals which enhance the wellbeing of intermarried Filipino women in rural and regional Tasmania.

## **6.2. Acculturation problems**

When intermarried Filipino women arrive at the host country, they are faced with the need to learn the appropriate behaviours and values suited for a smooth social cultural interaction. As Gupta (2006) Weisner (1993) and Sandhu (1997) point out that when cultural contexts change, old values and priorities change with resultant behaviour changes. Portes (1996) states that adaptation to the new social norms, cultural values, and daily behaviours of the dominant group almost always causes unavoidable psychological distresses and problems for members of the acculturating groups. Several factors influence the early stage of acculturation. Such factors are age, highest level of education, length of stay in Tasmania, and English



language proficiency. It is also important to note that these acculturation problems have a direct effect on the health and wellbeing of the intermarried Filipino women participants. The following section will discuss these factors and their influences on the intermarried Filipino women participants' acculturation strategies, and health and wellbeing as well as their access to health care services.

### **6.2.1. Age**

Age is one of the important factors that will likely affect a person's health particularly for migrants settling into a new cultural environment, such as the participants in this research. Their age plays a vital role in determining the way they handle certain changes in their health and wellbeing as well as changes in the environment in general.

In this research, the intermarried Filipino women participant's age group is found to be an important factor in evaluating their health. In the current global context, marriages between people from different racial backgrounds are quite common due to the availability of many networking services and many of these women marry at an early age. In this study, the participants' age/age group is examined in reference to their acculturation strategies, views about health and wellbeing as well as their access to health care services. It is notable to say that the chi-square test between the participants' age group and their views towards health concept, access to health care services and personal wellbeing did not come up to be significant like for example: Q14. Healthy lifestyle is vital to my wellbeing in Australia which gained a p-value of .6932 and Q35. Personal relationship has a p-value of .4372. However, qualitative data findings show that age group of the participants does play an important part to their health and wellbeing as well as to their access of health care services. The interview data analysis has identified that intermarried Filipino women participants are younger than her Australian husbands. In this case, their age gap was examined to find out whether this affects their relationship and their health and wellbeing. Two main points stand out from the analysis. Firstly, the older they are, the more mature they are in thinking. In other words, they are more likely to better handle different challenges in their health and wellbeing in the acculturation

process. Secondly, that the intermarried Filipino women participants are younger than their Australian husbands is an advantage for them. However, it also has a downside. They become very dependent on their husbands and this is not to their advantage, particularly when their husbands are heavily occupied by work and under pressure. Therefore, it is important for them to learn and handle things independently, and to learn to accept the changes in their present life.

A study of Ng and Omariba (2010) shows similar findings to this study. They found out that age as a health determinant provides migrants the opportunity to understand the migration process, especially its long-term effects on the migrants and their children. Ng and Omariba further point out that those who migrate at older ages have mental health advantage, suggesting that these women are better prepared to handle the challenges of settling and living in a new country.

Very few research studies examine age as a determinant to health and wellbeing for women engaged in interracial marriages. Most studies that consider age as a determinant are those dealing with young people studying outside their countries and age is the main factor in determining the way they handle the new culture, etc.

Apart from the participants' age, another factor that contributes to the acculturation issues is the level of education which will be discussed in the following section.

### **6.2.2. Highest level of education**

Education is an important factor that enhances a person's health and wellbeing. According to Cannon (2008), a high level of education equips an individual with the skills to cope with day to day challenges, and further enables an individual or migrant to participate more fully in the employment market, the economic market, and the communities. In contrast, Buckland (2004) states that generally people with low education levels have poorer health status and are more vulnerable in terms of employment and managing change.

For migrants, education is often considered as a big factor for a better life in a new country. It is because migrating to a different country is like entering a new world: a new environment, a new language, a new culture, etc. What are not new are they themselves. In most instances, migrants, like the intermarried Filipino women participants, find it difficult to acculturate themselves to their new “called-home”. However, from the data analysis, the participant’s highest level of education has a strong impact on her views about health, health concept, and access to health care services as well as to her acculturation process. As identified in the survey, more than half of the participants are university graduates and in spite of this, those participants having attained a high level of educational still encounter some problems just as those who are not university graduates. Therefore, it is reasonable to say that the level of education does affect their acculturation and their handling of good health and wellbeing. However, their level of education is superseded by their cultural views and beliefs. The Filipino culture is rich with traditional beliefs and practices in terms of looking after the health. The traditional view on health care is deeply affected by culture as explained in the following statement.

*Culture affects almost everything we do, think and feel. It shapes our habits, behaviour, language and personal style. It affects how we talk, make love, build homes and die. Culture also affects all the things that we take for granted and what we question.*(Salcedo, Peralta, Ronquillo, & Espiritu, 1999, p. 12)

Educational attainment is associated with almost every measure of population health (Ungerleider, 2004) and in this study the length of stay of the participants’ in rural Tasmania is also investigated to find out its effects on the participants’ adaptation and their health and wellbeing.

### **6.2.3. Length of stay in Tasmania**

Research on the health status of migrants suggests that recent immigrants (with less than 2 years of residence in the host country) are, upon their arrival, healthy overall, with notable exceptions for some health conditions, such as certain

infectious diseases (Davey-Smith, 2000; Mulvihill, Mailloux, & Atkin, 2002; Vissandjee, Desmeules, Cao, Abdool, & Kazanjian, 2004). Such finding complements the result of this study as presented in figure 4.29 (in Chapter 4 quantitative data analysis) that the health status of the intermarried Filipino women in their first 2 years of stay in rural Tasmania was generally good. When the participants were asked in the survey to rate their health status they mainly indicated that they were 'good, very good, and excellent'. The reason for this, according to the qualitative findings, is that intermarried Filipino women participants have to undergo a medical examination prior to their entry into Australia. Some of them had to wait for their visas for 8 to 11 months or even a year just for health clearance. However, after many years of stay in rural Tasmania, their health starts to decline (refer to figure 4.29 in Chapter 4) as they encounter challenges in a new cultural environment. Vissandjee et al., (2004) also confirm this result that healthy immigrant effect disappears over a period of time. Women who have migrated to and resided in Canada for 10 years and over are more likely to report poor health than Canadian born women.

In particular, the quantitative data findings show that the length of stay of the intermarried Filipino women participants in rural Tasmania affects their physical health in terms of the following aspects: absence of Filipino food, personal relationship and their safety. It is interesting to note that quantitative data finding shows contrasting result from the qualitative data analysis in terms of: Q8. The absence of Filipino food preferences affects my diet. As explained in chapter 4 (quantitative data analysis chapter) the longer the participants' stay in Tasmania the lesser they crave for Filipino food and the better they have adjusted to the food available in the host country. However, the interpretation of qualitative data findings is that the longer they live in rural Tasmania the more they crave for Filipino dishes or food. It means that they are facing serious problems because food is the ultimate source of health and goodness. Therefore they have to learn to adopt and eat the food available to the host country. This is not an easy process in the participants' migration journey, as their health and wellbeing has been affected. However, in some instances the longer their stay in the host country, the better

their personal relationship will be, they feel more secured and safe and the more new friends they make with their fellow Filipinos who are considered as family members. In this case, their length of stay in rural Tasmania becomes a positive factor that facilitates their acculturation as well as enhances their health and wellbeing because they establish a social connection not only to their partner and in-laws but as well as with the same ethnic group. Another positive outcome is that they can speak the same native language which makes them feel more comfortable in interpersonal communication. Being able to speak the same language is a 'confidant factor' to the participants. As discussed in the section below, the significance of English language proficiency to the participants' health and wellbeing is another important factor.

#### **6.2.4. English language proficiency**

The participants' English language proficiency is identified as the most influential factor that affects virtually all areas of their health and wellbeing. It is worth noting that the findings from both quantitative and qualitative analyses do not only agree with each other but also confirm its significance.

Research on migrants in a new cultural environment indicates that language (English) is a big barrier to their acculturation. The ability of the migrants to speak English is a big factor affecting the adaptation to the new cultural environment as well as the access to different public services such as bank, supermarket, etc. It is a big advantage for those participants who can communicate well in English because they are confident enough to use the available resources as well as to find information about the mainstream culture to improve their health and wellbeing.

However, it should be noted that ironically some participants with good ability to speak the language are still apprehensive in acquiring information and accessing available resources. This situation has put them in a disadvantaged position. Data findings of this research show both positive and negative results of being proficient in English. Thus it should be recognised that the participant's personality also affects the way they utilise their English language ability. As clearly demonstrated

from both data analysis chapters, the participants' English language proficiency plays different roles depending on the personality of the participants. The quantitative analysis shows that English proficiency helps the participants in acquiring information and in accessing health care services. However, the qualitative analysis shows that it is not only a significant factor that enhances health and wellbeing but also a barrier in terms of interpersonal relationship. Participants from the interviews admitted that even though they can speak the language well enough, they still feel anxious about voicing out their true emotions and feelings towards their husband, in-laws and friends.

Participants have a different degree of acculturation to the mainstream culture; however they share common experiences, views and beliefs which in one way or another make them feel that they belong together as one community. The section below will explain the different health concept and views of the intermarried Filipino women participants that have greatly influenced their acculturation as well as their health and wellbeing.

### **6.3. Health concepts and views about health and health care in rural and regional Tasmania**

Chapter 2 (literature review) presented the health and wellbeing views and beliefs of the Filipino women found in the existing literature. This chapter will discuss the findings as identified in the data analysis. The present findings aim to contribute something new to the existing literature and possibly to give some insights into not only intermarried Filipino women but also any Filipino women immigrants.

Intermarried Filipino women bring with them their views and attitudes about health and wellbeing to their new land. The question is how these views and attitudes affect their health and wellbeing as well as their acculturation process. For the purposes of this research, the views are classified into three themes: health matters; cultural views; and issues on access to health care services.

### **6.3.1. Health matters**

The health matters addressed here concern the different health views affecting the health and wellbeing of the intermarried Filipino women participants.

#### **6.3.1.1. Proper nutrition**

Intermarried Filipino women participants view nutrition as an ultimate factor for daily survival. It is their tradition to have three descent meals a day and two snacks (morning and afternoon). The statistical results in Chapter 4 confirm this, as 95.1% of all participants “agreed” and “strongly agreed” to this question Q15. Proper nutrition is important for my health and wellbeing. In addition, participants from the interviews stated that the absence of Filipino food choices affects their diet. Therefore, being in a new cultural environment and having to adopt new sets of diet have put their health at risk because the Australian diet is totally different from their own. Wilkison and Marmot’s (2003) study finds that a good diet and adequate food supply are central for promoting health and wellbeing. Shortage of food and lack of variety causes malnutrition and deficiency diseases. Excess intake (also a form of malnutrition) contributes to cardiovascular diseases, diabetes, cancer, degenerative eye diseases, obesity and dental caries.

The findings of this research is related to Wilkison and Marmot’s (2003) findings in a sense that because of the absence of familiar food items, some intermarried Filipino women participants have difficulty in finding alternatives while others are more likely to eat the available food due to its new appeal and availability. There are also certain reactions to their health. Some get sick because they are not used to the food, some put on weight and have problems to lose weight.

Alongside the differences in diet practice, intermarried Filipino women participants also have a different concept of proper nutrition. In Farrales and Chapman’s (1999) research about “Filipino women living in Canada: Constructing meanings of body, food and health”, they point out that Filipino beliefs value fatness which means that they just eat fat and rice, and maximising disease. This findings by Farrales and Chapman (1999) are similar to the findings of this study in which the participants tend to eat more as they want to make sure that they do not lose weight. It is

common in the Filipino health concept and beliefs that if they are far away from home and looking thin means they are not being cared for properly and that they are not happy. Therefore, they want to look 'better' physically to match their cultural concept of being healthy.

*When I went home in the Philippines to visit my family, they were not happy to see me looking very thin. Even our relatives made a fuss about my weight. They think that I have a problematic marriage. (Participant 05)*

A contradictory comment from another participant is:

*My family were very surprised to see me putting on so much weight. Well, well they said, obviously you were being taken care of very well. It also looked as if you were very happy. (Participant 4)*

The comments made by the participants' show that their understanding of proper nutrition depends on how they look physically which is similar to how they view health as stated in the qualitative data analysis chapter, that is, health is free from diseases and that one's mind can function well.

Access to nutritious food is vitally important to peoples' health and wellbeing. It is impacted upon by levels of food literacy and also by geographical and socioeconomic location (Cannon, 2008). In the case of the participants, there is no question about the availability of nutritious food in the rural areas where they are living. The question lies in their longing for a familiar taste as native Filipino dishes is out of reach and there is no Asian shop around in the rural areas compared to the urban areas.

#### **6.3.1.2. Proper hygiene**

Based on the quantitative data results, the intermarried Filipino women participants consider proper hygiene the second most important factor affecting their health and wellbeing. Of all participants, 93.8% responded 'agree' and 'strongly agree' in terms of its importance to their health and wellbeing. Proper hygiene is every one's concern. The finding is not surprising because it is a common practice for Filipino



people to have a shower every morning and a bath before going to bed as a personal hygiene practice. They also brush their teeth more than other people would normally do as they brush their teeth every time after they eat particularly when they are at home. In the study of Rosa and Mo (2009) with regard to the Filipino Americans, they find out that, Filipinos highly value personal hygiene. They further emphasise that it is common for Filipinos to take multiple baths each day to maintain the proper balance of hot and cold in the body. They believe bathing in warm or cool water infused with herbs could restore balance. This study complements the results of the study of Rosa and Mo (2009). Filipinos, wherever they are in the world, retain their health views and practices because these are what they have been used to.

On the other hand, when asked about their traditional beliefs and practices, there are views and practices not acceptable in the Australian health practice but stressed by the participants as important during the interviews. This is the practice of avoiding a wash or a shower right after giving birth because of the belief of “bughat” – strain in the muscle.

*After giving birth, I felt so tired but the midwife asked me to have a shower and I was shocked because I know it is not good for me. But when she told me that I needed to be clean, I couldn't say a thing anymore. I understood what she was saying but my concern was I was going to be sick. I would have “bughat”. (Participant 6)*

#### **6.3.1.3. Healthy lifestyle**

The participants believe in the importance of a healthy lifestyle to their wellbeing in a new cultural environment. Most participants (87.5%) responded ‘agree’ and ‘strongly agree’ when answering question Q14 in-“Healthy lifestyle is vital to my wellbeing in Australia” in the survey. Based on the qualitative data analysis, the participants find it hard to adapt to the lifestyle of the host cultural environment because of some cultural differences. Data findings from both research instruments complement with each other. Therefore a healthy lifestyle does play a significant factor in influencing the participants’ life and wellbeing. According to Lyons and

Langille (2000), a healthy lifestyle is a valuable resource for reducing the incidence and impact of health problems, for recovery, for coping with life stressors, and for improving quality of life.

The participants also pointed out that the kind of lifestyle they have had in the Philippines was quite simple and easy compared to what they have here. As a result of adopting the new lifestyle of the host country, their health may deteriorate notably because of the Australian dietary habits and activity patterns. One of the important findings of this research in terms of lifestyle is that the participants have realised that the kind of lifestyle here is better and they are happy to adopt it for improving their health and wellbeing.

*Not until I came to live here in Tasmania, I have never realised that daily exercise is a part of lifestyle and how good it is for my health. So regardless of how busy I am, I always try to have some walking or jogging exercises.*

(Participant 3)

#### **6.3.1.4. Physical health**

Physical health is referred to here as being physically fit and healthy which means that the body is working properly and is able to do things such as moving around, fighting off disease, repairing injuries and keeping mind working well (Mason, 2010).

In the survey, the research tried to understand the participants' state of physical health by asking the question if their physical health influences or limits their interaction with others (Q16). The results turn out to be remarkable as 35.9% of the participants responded 'agree' and 14.1% responded 'strongly agree'. In general, half of the total number of participants thinks that their physical health limits their interaction with others particularly with mainstream Australians and their fellow Filipinos. The qualitative data analysis further elaborates the finding: the participants define health as being physically healthy and happy. Therefore, if the participants' for instance is sick physically, she is not able to socialise with her fellow Filipinos and mainstream Australians. This view affects their health and wellbeing

because it hinders their ability to maintain an interaction with family, friends and neighbours. In some ways, it also brings them closer to their family and friends. As explained in the qualitative data analysis chapter (Chapter 5), Filipino community helps each other. Therefore if someone is physically sick, they offer their support, physically and spiritually. The Filipinos' cultural belief is that sickness or ill health brings people closer.

One of the factors that affect the participants' physical health is the weather conditions in rural Tasmania. The weather conditions and their effects on the health of the participants are discussed below.

#### **6.3.1.5. Changes of weather conditions**

The weather conditions in rural Tasmania are unpredictable. Throughout the year, the climate is more like winter and autumn. It is surprising to note that in the quantitative data analysis, only 54.8% of the participants said that the changes in weather conditions do affect their health, whereas in the qualitative findings, all the intermarried Filipino women interviewed emphasised the effects of the changes in weather conditions on their health. One important aspect to note here is that the use of both quantitative and qualitative approaches in research makes the findings more insightful.

The reason for the inclusion of the examination of the weather condition in this study is because the participants came from a tropical country and as explained in their views about health; their health is in accordance with a balance between hot and cold. Therefore the changes in weather conditions greatly play an important part in affecting their health and wellbeing.

Early research about changes in weather conditions shows that they have an enormous effect on people's health. According to Irwin (1959), the immediate effect of any change in the weather shows up in the blood pressure, pulse, body temperature, urine and actually in all metabolic and chemical processes of the body. Some people adjust satisfactorily, others cannot. Irwin (1959) further explains that weather in itself rarely brings on diseases. But pronounced drop or rise in

temperature, humidity and barometric pressure altering the body functions is just enough to throw them off balance. For example during the months from April to September when the weather is cold, many people get sick, such as having a cold or flu, runny nose, woofing cough, gastro, etc. If many mainstream Australians suffer from these illnesses during this time of the year, one would expect more Filipino migrants to suffer the same. According to Patz, Engelberg and Last (2000), many diseases are influenced by weather conditions or display strong seasonality, suggestive of a possible climatic contribution. Analysis of the potential extremes associated with climate change is both complex and important. Extreme weather conditions influence the health outcomes that the public health community will have to handle (Corvalan, Gopalan, & Llanso, 2003). Therefore, the variation of weather temperature is what affects the health of the intermarried Filipino women.

*Climate change may affect health through a range of pathways, e.g., as a result of increased frequency and intensity of heat waves, reduction in cold-related deaths, increased floods and droughts, changes in the distribution of vector-borne diseases, and effects on the risk of disasters and malnutrition.*

(Haines, Kovats, Campbell-Lendrum, & Corvalan, 2006, p. abstract)

Climate is an important determinant for human health. Both weather and climatic variables can be seen as factors that directly or indirectly impact on human health. Moreover, these are not expected to remain constant, and it is likely their overall impacts on human health will increase (Corvalan, et al., 2003).

### **6.3.2. Cultural views**

This section tackles the cultural views specifically on the care of family, traditional Filipino views, beliefs, faith and religion.

#### **6.3.2.1. Care of family**

‘Strong family ties have characterised Filipino life throughout the centuries’ (Salcedo, et al., 1999, p. 62). Since this study deals with intermarried Filipino women, it is necessary to investigate the importance of family care to them most particularly in times of sickness. The findings show that 88.7% of all participants

agreed to the importance of family care particularly when they are sick, while all in the interviews strongly emphasised their needs and longing for care from their family when they are sick. Among the participants in the interviews, only two have had serious conditions, while the others have experienced common illnesses such as a cold, flu, high fever, etc. However, the data findings show that whether the illness is serious or not, the presence of family members and its caring effect is still needed. As for the two participants who have very sick, this is what they said:

*Being so sick and not having my family around made me sicker. I needed them so badly but what could I do? Luckily I had my husband who came and visited me in the hospital every day. (Participant 8)*

*I was so sick and even underwent an open heart surgery and it was hard because I was there by myself. No family members around and not even my husband as he was looking after our children. When you go through all that you think of your family back home most especially my Mama. I am pretty sure if she were here she would look after me and my siblings would stay by my side. (Participant 7)*

In the study of Tan-Alora and Lumitao (2001) on Filipinos, they found out that in the onset of illness, the sick person brings into the clinical setting his or her social support network when this person is in need of family support. In this case, the entire family participates in the care of the patient who is a family member. Another family member typically accompanies the patient when he or she needs to see a physician or is hospitalised. This family member acts as an aide, interpreter and advisor; helps move the patient around; provides the medical history and participates in and even exempts the patient from any decision making. An ill family member is advised not to worry about anything but to focus on resting and becoming healthy again.

This study and Tan-Alora and Lumitao's study complement each other. It only shows that Filipinos' views and beliefs about family care are important to their health.

#### **6.3.2.2. Traditional Filipino views and beliefs**

In the survey questionnaire, intermarried Filipino women participants were asked if they still hold traditional beliefs and practices in looking after their health. It is interesting to note that 75.6% 'agreed' and 'strongly agreed'. This finding is supported by the interview finding as the participants elaborated and emphasised their difficulties in adjusting to and adopting the practices of the host culture. Filipinos in Australia are still inclined to use alternative therapies such as getting a traditional massage or "hilot" and at the same time taking the doctor's prescribed medications (Kumar, 2010).

#### **6.3.2.3. Faith and religion**

Trust in God is the most important facet of Filipino life. About 80% to 85% of Filipinos are catholic (Tan-Alora & Lumitao, 2001). In a survey conducted by Miranda (cited in Tan-Alora & Lumitao, 2001), 61% of her respondents ranked trust in God as the most important value for child-rearing. Miranda's survey involved Filipino women; hence it is relevant to this study. Data analysis in this study shows that the participants' consider their faith and religion as an important aspect of their health and wellbeing. Qualitative data findings also indicate a strong impact of participants' faith and religion on their lives.

*I believe that someone up there is looking after me and my family and I am so thankful to Him. That is why I attend a mass every Sunday. I also believe that sickness sometimes is a reminder to us not to forget Him. (Participant 1)*

There are instances that "Filipino people will travel overseas or interstate to seek miracles from patronised saint or preacher whom they believe possesses a healing power" (South Eastern Region Migrant Resource Centre, 2010).

### **6.3.3. Issues in accessing health care in rural and regional Tasmania**

#### **6.3.3.1. Language**

Many migrants face various communication problems when seeking care. This can be caused by cultural and language differences preventing the migrants from

understanding the bureaucracies of the health system and from expressing their needs (Davies, Basten, & Frattini, n.d.). This statement agrees with the findings of this study. As the data analysis from both quantitative and qualitative approaches show, even though participants can speak well in English, they still encounter difficulty in accessing health care services due to the differences in the manner of speech. English language may be known or spoken around the world but Australian English is still different to the participants.

Half of the participants can speak good English and they tend to prefer to be treated by a female doctor. Hence this preference affects their access to available services because not many health care professionals are available in the rural areas. Thus, they do not have a choice.

Another noteworthy result found in the data analysis is that the participants find health care professionals very approachable. This is a good sign that they would not be apprehensive in approaching health care professionals regardless of their gender.

Salcedo et al. (1999) points out that “language enables us to share with others our ideas, thoughts, fears, desires, and experiences. Language is the means by which symbols are created and transmitted” (p. 13). Therefore to speak and understand Australian English is highly important for the participants to access the health care services.

#### **6.3.3.2. Understanding between patient and health care professionals**

The participants’ views and practices are different from those of the health care professionals and therefore there can be difficulties in understanding each other and barriers inhibiting effective treatment. According to Eshiett and Parry (2003), health care professionals may not understand the culture of those of a different race to be able to expect how they behave during illness. Therefore it is important for the health care professionals to understand the likely behaviour of the patients before dealing with them and it is evident in the quantitative data analysis that more than half of the participants ‘agreed and strongly agreed’ to its importance. In

some respects, it is also necessary for the participants to find information about the available services to be able to understand the system when they seek treatment. Learning about available health care services is to acquire “health literacy which means more than being able to read the pamphlets and successfully make appointments” (Cannon, 2008; Nutbeam, 2001, p. 10).

Data findings show that the participants’ ways of finding information are through the media such as newspaper, magazines, television and radio. In a highly advanced world today, web -searching is also used as a means of finding information. However, not all participants have the capabilities to do so and therefore this becomes a problem because there is a tendency for them to rely on what is given to them.

#### **6.4. Social and cultural capitals which enhance the wellbeing of intermarried Filipino women in rural and regional Tasmania**

The participants’ systems of social capital vary depending on their views and beliefs as well as their capabilities in terms of adaptation and decision making. To answer research objective 4 about the health and wellbeing enhancing social capital of the participants, this study finds two important factors: (1) social support network through Filipino community and (2) the media and the internet.

As an individual asset, social capital consists of a person’s relationship to available social resources. As a characteristic of communities, it consists of attributes such as trust, reciprocity, collective action and participation. Closely related to community social capital is the concept of collective efficacy (Ledogar & Fleming, 2008).

##### **6.4.1. Social support network**

Social support and good social relations make an important contribution to health. Social support helps give people the emotional and practical resources they need. Belonging to a social network makes people feel esteemed, being cared for, loved,



and valued. This has a powerful protective effect on health. Supportive relationships may also encourage healthier behaviour patterns (Wilkinson & Marmot, 2003).

Social support network is vital to intermarried Filipino women's wellbeing. A lack of social support, large geographical distances to members of the social network, and high expectations from relatives in the countries of origin are sometimes additional stressors leading to mental health problems and risky health behaviours among migrants (Bhugra, 2004; Kristiansen, Mygind, & Krasnik, 2007). Being able to rely on others for social support may reduce stress or acute anxiety (Knoll & Schwarzer). This is relevant to intermarried Filipino women as they value friendship and social support. *Bayanihan*, is a term meaning supporting each other in the Philippines. According to the participants, depression and too much stress are not common words in everyday language in the Philippines, but not so in Australia. They attributed this to the support in their home country where every Filipino gets support from not only the family but also the neighbourhood. Living in a different cultural environment, social support "serves as a powerful buffer against stressful life events" (Knoll & Schwarzer, p. 5) which is true to most of the intermarried Filipino women participants. However, two participants' in the semi-structured interviews commented that social network or support was of no use to them as they believed that it would only ruin their relationship with their husbands. It is important to stress that social support and networking does have positive and negative effects and the nature of the effects depends on the degree of understanding of this concept by the migrants or individuals.

#### **6.4.2. The media and the internet**

The media and the internet play an important role in the enhancement of the wellbeing of the participants. The participants claimed that watching television and reading magazines is a pastime to keep them occupied. It helps ease their loneliness. Having internet connection and being able to use the internet are big contributors to their wellbeing and according to some participants', they can easily connect with their loved ones through exchanging emails as there is no longer waiting periods compared to the traditional postal mails.

## **6.5. Conclusion**

The use of quantitative and qualitative research methods in this study has made the data findings insightful as it presents both the statistical side and the perspective side of the participants. The interpretation of the integrated data findings as presented in this chapter has enriched existing literature. Several research studies on Filipinos tackle mainly very specific concepts such as the importance of social support, the effects of Filipino cultural beliefs on Filipino nurses working abroad, Filipino remittances, the disadvantageous situations of Filipino women in Australia like exploitation, trafficking, etc. This study however provides a variety of important insights into the factors affecting their health and wellbeing, their access to health care services and their acculturation process. Four important results are highlighted and summarised below:

- Age, level of education, length of stay in Tasmania and English language proficiency are the main factors affecting the views and health behaviours of the participants during the acculturation process.
- Concepts and views about proper nutrition, proper hygiene, healthy lifestyle, physical health and changes in weather conditions are identified as factors significantly affecting the health of the participants and their views about health care in rural Tasmania.
- Language barrier and understanding between the participants and health care professionals are issues when accessing health care services.
- Social support from the Filipino community, the media and access to the internet is important social and cultural capitals that enhance the wellbeing of the participants.

# **Chapter 7 – Conclusion and Reflection**

## **7.1. Introduction**

Health and wellbeing are a significant issue in every society. It indicates how healthy a population is. It is also the major source of strength for every individual. It is expected that people who have good health and wellbeing have a happy and content life. The question is how people keep themselves healthy and happy. For every migrant like the intermarried Filipino women, health and wellbeing in their new-called home is fundamental for their survival in a new cultural and social environment. This is the basis of this research with a specific focus, to find out the health and wellbeing of intermarried Filipino women in rural Tasmania. The setting of the study “rural” connotes problems in itself. When people think of a rural area, they think of a small community. A community that does not have everything people need particularly in terms of resources like health care services and other community services. This chapter will review and discuss the overall outcomes of this study. Four main themes are selected for the discussion to capture the essential aspects of the study. The chapter starts with the achievement of the study. In this section the aims and objectives are revisited along with a discussion on how they were achieved and certain issues that arose during the study as a research journey. The major points of the chapters in the thesis will also be raised and briefly discussed. It then moves on to examine future research, in connection with the present study. Some recommendations for health care professionals as well as to the migrants will be advanced.

## **7.2. Achievement of the study**

The way the discussion is presented in this section is based on the following questions:

- Was the research successful?

- What were the main findings?
- How do they affect the current views?

### **7.2.1. Was the research successful?**

In every dissertation, the principal goal of the researcher is to make sure that the study is successful. The researcher cannot fully say if the study is successful or not until the whole study is finished. In regards with this study, the researcher begins to check whether the objectives are fully attained or not. In doing so, the steps and the processes of acquiring information from the existing literature, data collections as well as the data analysis are reviewed. Prior to data collection, gathering of academic research and scholarly journal articles were first given importance to see what has already been dealt with in the field of interracial marriage and health and wellbeing. This is the starting point which is needed for the advancement of knowledge.

The following factors have been crucial in determining the success of this research:

- The amount of sources gathered in the literature review of this thesis is a confirmation that research aims and objectives were appropriately formulated and worthwhile for conducting research dealing with health and wellbeing on intermarriage of Filipino women in the Tasmania context.
- The use of mixed methods design (combination of quantitative and qualitative) enhanced the data collection and data analysis on the basis that insights gained from different perspectives were obtained.
- The number of participants who participated in the study which is n=145 and the response rate of 58% reinforced significant findings in relations to the aims and objectives. Approximately 15 of these (from 145) participants willingly participated in the semi-structured interview.

- Data analysis findings both from the survey and interviews are very complementary. It shows intricate connection with previous research and the literature dealing with the common issues.

The research output has been shared with researchers in various discourses such as:

- Initial findings from the first phase of the research was reported in a book chapter entitled “Health and wellbeing: Social perspective” that was recently published by NOVA Science Publishers Inc.
- During the course of writing up the literature review chapter, the researcher was able to communicate the result of the review through a paper presented in an international conference in the Philippines (Research: Response to challenges of globalisation; 27-28 February 2008, Ilo-Ilo City Philippines) entitled “Health and wellbeing of intermarried Filipino women in Tasmania”
- Further results of the data analysis formed a basis for two more papers presented at the 4<sup>th</sup> International conference on community health nursing research, entitled: “Behavioural Strategies of Intermarried Filipino Women in Dealing with Health Issues in Rural Tasmania” and “Intermarriage and Health Issues in a Rural Context”.

In the course of the study certain issues arose that affected the researcher academically and personally. Academically, it is important to recognise that one learns about research by doing research. The research beamed not only an academic journey but also a personal one. The only minor issue that the researcher encountered in the data collection period was the failure to obtain the total population target of 250 in Filipino women Tasmania. Being a Filipino woman herself, the researcher expected the support of her fellow Filipina. However, that was not the case. The researcher came to the realisation that her fellow Filipina were also migrants with challenges to face in a new environment. Being migrants they preferred to remain in their safety zone, avoiding being exposed to the mainstream. Though it was clearly stated in the invitation letter about the

assurance of anonymity and confidentiality of the participants involved in the study, they still had some reservation. Having been involved in this research, the researcher has realised that being a Filipino researcher could also be a hindrance to the recruitment of other intermarried Filipino women for the study.

### 7.2.2. What were the main findings?

The findings of this study are presented in Table 7.1. This is to draw some comparison from the existing literature to the present study.

Table 7-1 *Health and wellbeing issues found in the literature and from the present study data findings*

| F I N D I N G S   |   |  |
|---|---|--|
| Existing literature   | Quantitative data analysis  | Qualitative data analysis  |
| 1. Intermarried Filipino women's health issues <ul style="list-style-type: none"> <li>– Concept views and attitude about health</li> <li>– Access to health care services               <ul style="list-style-type: none"> <li>- Language barrier</li> <li>- Cultural barrier</li> </ul> </li> <li>– Health problems</li> </ul> | 1. Health and wellbeing issues <ul style="list-style-type: none"> <li>– Health concept</li> <li>– Access to health care services</li> <li>– Personal wellbeing</li> <li>– General health and wellbeing</li> </ul> | 1. Health and wellbeing issues <ul style="list-style-type: none"> <li>– Cultural issues               <ul style="list-style-type: none"> <li>- Personal and traditional views</li> <li>- Cultural adjustment</li> <li>- Stress and depression</li> <li>- Eating habits and food</li> </ul> </li> <li>– Migration issues               <ul style="list-style-type: none"> <li>- Identity, self-concept and new social role</li> <li>- Loneliness and homesickness</li> </ul> </li> <li>– Social issues               <ul style="list-style-type: none"> <li>- Sense of belonging</li> <li>- Social networking</li> <li>- Lifestyle</li> </ul> </li> <li>– Marital issues               <ul style="list-style-type: none"> <li>- Age gap</li> <li>- Expectations and disappointments</li> <li>- Finances and supporting</li> </ul> </li> </ul> |

| F I N D I N G S   |  |   |
|---|--|---|
| Existing literature   | Quantitative data analysis   | Qualitative data analysis   |
|   |  | family back home  |
| 2. Wellbeing issues <ul style="list-style-type: none"> <li>– Familiarity with mainstream Australian culture</li> <li>– Educational background</li> <li>– Stereotyping</li> <li>– Acculturation               <ul style="list-style-type: none"> <li>- Interpersonal relationship and social networking</li> <li>- Cultural shock</li> <li>- Migration issues</li> <li>- Marital issues</li> </ul> </li> </ul> | 2. Factors that affects health and wellbeing <ul style="list-style-type: none"> <li>– Age group</li> <li>– Highest level of education</li> <li>– English language proficiency</li> <li>– Length of stay in Tasmania</li> </ul> | 2. Issues in access of health care services <ul style="list-style-type: none"> <li>– Personal expectation of health care services (before and after)</li> <li>– Barriers to access of health care services               <ul style="list-style-type: none"> <li>- Language barrier</li> <li>- Traditional Filipino beliefs and practices</li> </ul> </li> </ul> |
|   |  | 3. Coping behaviour <ul style="list-style-type: none"> <li>– Awareness</li> <li>– Acceptance</li> <li>– Social networking</li> <li>– Faith and religion</li> </ul>  |

In Australia, most research involving intermarried Filipino women focuses on negative themes. Little attention was given to their health and wellbeing issues. Table 7.1 shows the different health and wellbeing issues in relation to the existing literature and the present study. The table shows what the present research brings to the knowledge in the field of research.

The data analysis results were presented in chapters 4 and 5. On the basis of the results gained from these two chapters. The following insights are derived:

- From the quantitative data analysis perspective, it is remarkable that the intermarried Filipino women's health concept was greatly affected by their culture in general.
- Quantitative data findings do not only show health related issues but also the personal and general wellbeing of the intermarried Filipino women (refer to chapter 4). These findings are useful to health care professionals and also to all Filipino women involved in interracial marriages. Four main factors were also identified that have significant impact on their health and

wellbeing: age gap, highest level of education, English language proficiency and length of stay in Tasmania. These sets of factors also confirm other research findings.

- Qualitative analysis reinforces quantitative data analysis. The major highlights of qualitative analysis are: data findings identified not only the different health and wellbeing issues but also coping behaviour. The coping behaviour found in the analysis is very important because this is one of the gaps which lead to this study. By identifying the coping behaviour, it can serve as a guide for other immigrants on how they might cope in the country they are going to migrate to. The coping behaviour such as awareness, acceptance, social networking and faith and religion highlight the lived experiences of the Filipino wives in a new land. Furthermore, it also convinces the view that Filipino women tend to accept what is important at the present and they are strong in their determination to succeed. This could be interplayed in terms of their strong faith and trust in their religion.
- Literature review show cases the different health and wellbeing issues identified from the existing literature. It is safe to say, that the present study thus presents new findings that will greatly contribute to the field of health and wellbeing research.
- Literature reviews pointed out that culture and language barriers play a significant role in the health and wellbeing of the intermarried Filipino women. It is interesting to know that wherever the intermarried Filipino women are in the world and whether they are involved in interracial marriages or being a domestic and skilled worker, the common issues they typically have is their views and concept of health. The underlying reason behind this is Filipino's health in general is believed in the Principle of Balance. In this principle some practices are myths and some are facts. However, Filipinos are superstitious believers; they even adapt and practice the so-called superstitious beliefs.



Surprisingly, none of the intermarried Filipino women in the present study reported serious health problems in a sense of being hospitalised. Yet, the health and wellbeing issues they were facing disturbed their migration and adaptation process. To analyse the whole findings, the health and wellbeing issues do affect the intermarried Filipino women, mentally, emotionally, physically and spiritually. Important lessons learned from this study are that no one can be ready for immigration. Even a migrant can speak English well and be well educated; they can still not be fully –equipped for the migration journey. As the migrant progresses through their journey, he or she will experience and discover different things. Migrants will only learn to deal with the problems once it is in front of him or her.

### **7.2.3. How do they affect the current views of the researcher?**

A research project is metaphorically a dynamic journey of a researcher. How objective a researcher tries to be, it is almost impossible to separate the researcher as a person from the research as an entity. Consciously and unconsciously, there is an intricate interaction between the two factors. Thus in this part of the thesis, the first person pronoun 'I' and 'me' will be used to present the personal dimension of the researcher into her research.

I will address this question in response with three discourses: as a researcher; as a migrant and as a participant.

As a researcher, the present study about the Filipino women inspires me to embark on this journey. I feel that I am not just undertaking an academic task, but fundamentally the project itself gives me an opportunity to know more about Filipino culture and how it is used in a foreign land. I believe that a journey outwards is a journey inwards. The project has helped me to open a window into my life. Academically, the research project has improved my intellectual ability. I have learnt not to take things for granted and that critical thinking is an important way to question issues and problems in an academic discourse. Technological skills have also been considered as important learning through the course of this journey. I have learned to use different computer software specifically for data analysis

purposes such SPSS and Nvivo. Other important software that I believe to be more useful in the years to come is proper use of Endnote and formatting word document for academic writing. Personally, now that I have started this field there is no turning back. I should not underestimate my capabilities. Everyone who has the courage and determination to succeed should never hesitate to challenge themselves. Looking at the outcomes of my research as well as noting the remarks made by the conference audiences when I presented my initial findings have enhanced my self-esteem. This is one of the biggest academic achievements in my life. Presenting research findings implies co-teaching and co-learning with fellow researchers. Therefore, research is a collaborative educational activity in a community of learners.

As a migrant, this study made me realise that I have bigger obligations to myself in respect to my health and wellbeing than the mainstream cultural environment. It is easy to blame the differences of the host culture for migrants' problems. Indeed, that is what most research findings including the present study tend to indicate. Hence, if migrants have the confidence, knowledge, and strong fighting spirit, their migration journey should not be as hard as they have encountered. However, in saying this, one needs to note that every migrant is different. Each experience they encounter is unique. This is the reason for promoting more researchers investigating their lives.

As a participant, I am privileged to be part of the study. I believe that my experiences in some way may contribute to the fulfilment of this research. One remarkable experience that I would like to stress is that when I played my part as a participant by answering the survey questions and interview questions, I realised how my participants felt. The feeling of being given a chance to evaluate your own health and wellbeing status is empowering. The impact of this empowerment can be felt at any time throughout the research journey and afterwards. This thesis theme makes me realise that it is indeed very important to examine how we feel physically, mentally and emotionally, as our health and wellbeing are the most important aspect of our life.

To conclude this section, the overall effect of the present study to my personal value is that health and wellbeing are the most important aspects in our lives. I am confident that the present study is not only presenting statistical results and the findings will contribute to further knowledge for the academic discourse, but also contribute to develop personal growth of the researcher, intellectually, socially and emotionally.

### **7.3. Future research**

The current findings demonstrate the importance of further research on the health and wellbeing issues of the intermarried Filipino women in Australia in general. This is due to a lack of comprehensive information concerning their health status. Based on the existing literature, most studies in Australia concern about the sensational and negative aspects such as the mail-order bride, trafficking, stereotyping, etc. Thus the need for a more specific investigation about their health and wellbeing is important in this sense. This study investigated only intermarried Filipino women in rural Tasmania. Therefore future studies may examine a bigger population and a wider setting, so that more wide-ranging results from across the states and regions of Australia can be acquired.

From the academic discipline perspective, this study builds on and contributes to the knowledge and research in Social and Behavioural Science. Although studies in this discipline have examined the issues involved particularly, interracial marriages, rural studies and female migration there has not been enough information. As the world becomes more global and technically advanced migrants do not only face common issues but new emerging issues. Every issue and experience they encounter is notable because this will make research more proactive and responsive. As such this study provides additional insights into the new trend of interracial marriages involving Filipino women particularly in their health and wellbeing, their access to health care services and the way they acculturate themselves to the newly adopted country.

## **7.4. Recommendations**

To contribute to the Social Science Research, this study proposes a set of recommendations:

- Firstly, it is a basic requirement to have professional interpreters available at all times, in order for intermarried Filipino women and other non-English speaking migrants to be given proper help and treatment specifically in rural areas.
- Secondly, it is important for the health care providers to expand their knowledge and effort to understand the likely behaviour of migrants by participating in seminar series and conferences about migrants' cultures particularly in terms of health practices and health concepts. This will promote a more suitable healthy society for the migrants.
- Thirdly, intermarried Filipino women should give more serious effort to acquiring information about the services available in order to have enough knowledge on how they can also help themselves in the host cultural environment.
- Fourthly, over-all research findings should also be disseminated to the Filipino community all over Australia. In this way, research findings are not locked up in libraries and academic towers.
- Lastly, it will also be best to undergo a research regarding Australian husbands (married to Filipino women) and find out the effects of marrying Filipino women to their health and wellbeing, to see the other side of this research.

## **7.5. Concluding statement**

Two words are best to describe the concluding section: tensions and satisfaction. Tensions are signs of seeing the light at the end of the tunnel. Satisfactions are the feelings of having fulfilled the principal goal of this research. Having fulfilled the

investigation and presenting the data analysis findings as well as the entire thesis to the academic discourse is incomparable. As the researcher, I am grateful to have been given this chance to conduct this particular research topic (Health and wellbeing of intermarried Filipino women in rural Tasmania) simply because: I have heard, listened, communicated and learned about the different issues facing intermarried Filipino women. Filipino women migrants and the community in general need more research so that we can gain further understanding of their health and wellbeing and their status in the new cultural environment. This will ensure that all their concerns and worries are heard.

# References

- Abano, R. A. (2006). Issues and problems in Filipino-Australian Marriages. *Center for Migrant Advocacy KASAMA*, 20(3).
- ABS. (2000). *4102.0 - Australian Social Trends*.
- ABS. (2006). *Census of population and housing Tasmania (State) Country of birth of person (full classification list) by sex*. Retrieved 25 Jan 2010 from [www.censusdata.abs.gov.au](http://www.censusdata.abs.gov.au).
- ABS. (2010). *1307.6 - Tasmanian State regional Indicators*. Australian Bureau of Statistics Retrieved Retrieved 26 Feb 2011 from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1307.6Main+Features6Mar+2010>.
- ACORN. (2003). Speaking the language of care: language barriers to hospital access in America's cities Retrieved 11 Nov 2007, from [http://www.acorn.org/fileadmin/Additional\\_Accomplishments/National\\_report.pdf](http://www.acorn.org/fileadmin/Additional_Accomplishments/National_report.pdf)
- Adams, R. G., & Blieszner, R. (1995). Aging well with friends and family. *American Behavioral Scientist - Aging well in contemporary society*, 39(Special), 209-224.
- Agoncillo, T., & Guerrero, M. (1987). *History of the Filipino people*. Quezon City, Philippines: Garcia Publishing Company.
- Alati, R., Najman, J., & Williams, G. (2004). The Mental Health of Filipino-born women 5 and 14 years after they have given birth in Australia: A longitudinal study. *Health Sociology Review*, 13(2), 145-156.
- Alba, R., & Nee, V. (1999). Rethinking Assimilation Theory for a New Era of Immigration. In C. Hirschman, P. Kasinitz & J. DeWind (Eds.), *The Handbook*

*of International Migration: The American experience* (pp. 137-160). New York: Russell Sage Foundation.

Allan, G. (2003). A critique using grounded theory as a research method. *Electronic Journal of Business Research Methods*, 2(1), 1-10.

Allan, J. D. (1998). Explanatory Models of Overweight Among African American, Euro-American, and Mexican American Women. *Western Journal of Nursing Research*, 20(1), 45-66

Allotey, P., Manderson, J., Nikles, J., Reidpath, D., & Sauvarin, J. (1999). Philippines a Guide for Health Professionals. Retrieved 20 Feb 2009 from [http://www.health.qld.gov.au/multicultural/health\\_workers/philippn.pdf](http://www.health.qld.gov.au/multicultural/health_workers/philippn.pdf)

Alouise, N. J. (1998). Interracial Marriages and the Effects on Children. Retrieved 5 Jul 2009 from <http://academic.udayton.edu/race/04needs/s98alouis.htm>

Anderson, J. N. (1983). Health and illness in Pilipino immigrants. *Western Journal of Medicine*, 139(6), 811-819.

Angeles, L., & Sunanta, S. (2007). Exotic love at your fingertips: Intermarriage websites, genedered representation, and the transnational migration of Filipino and Thai women. *Kasarinlan: Philippine Journal of Third World Studies*, 22(1), 3-31.

Asghari-Fard, M., & Hossain, S. Z. (2008). What are the implications of Australian multiculturalism for the development of health policies and services? Does cultural awareness optimise quality of care? Retrieved 4 Aug 2010 from [http://www.rcna.org.au/Userfiles/asghari-fard\\_mona-1.pdf](http://www.rcna.org.au/Userfiles/asghari-fard_mona-1.pdf)

Ashcroft, J., & Lynas, P. (2008). Investigating in relationships: Turning financial capital into social capital to improve wellbeing Retrieved 4 Mar 2009, from <http://www.relationshipsfoundation.org/download.php?id=218>

Beach, D. (1996). *The responsible conduct of research*. New York: VCH Publisher Inc.

- Becker, G. (2003). Culturally expressions of bodily awareness among chronically ill Filipino Americans. *Annals of Family Medicine*, 1, 113-118. doi: 10.1370/afm.39
- Bernard, J. (1998). "His" and "Her" marriage. In J. J. Macionis & N. V. Benokraitis (Eds.), *Seeing ourselves: Classic, contemporary, and cross-cultural readings in sociology* (pp. 305-311). New Jersey: Prentice Hall.
- Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Sociology: An International Review*, 46(1), 5-68. Retrieved 5 Sep 2011 from <http://www.ucd.ie/mcri/resources/Dermot%20Ryan%20Reading.pdf>
- Berry, J. W., & Sam, D. L. (1997). Acculturation and adaptation. In J. W. Berry, M. H. Segall & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology* (2nd ed., Vol. 3 Social Behavior and Applications, pp. 291-326). Needham Heights, MA: Allyn and Bacon.
- Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scand*, 109, 243-258.
- Bischoff, A., Tonnerre, C., Eytan, A., Bernstein, M., & Loutan, L. (1999). Addressing language barriers to health care, a survey of medical services in Switzerland. *Sozial- und Präventivmedizin/Social and Preventive Medicine*, 44(6), 248-256.
- Bollini, P., & Siem, H. (1995). Health needs of migrants. *World Health Organization (Europe)*, 48(6), 20-22.
- Bowen, S. (2001). Language barriers in access to health care. *Health Canada*. Retrieved 8 Oct 2010 from <http://www.hc-sc.gc.ca/hcs-sss/pubs/acces/2001-lang-acces/index-eng.php>
- Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, California: Sage Publications Inc.
- Bryman, A. (2004). *Social research methods* Oxford University Press.



- Buckland, S. (2004). *Health determinants Queensland 2004*. (0734529570). Queensland Health Retrieved 10 Feb 2010 from [http://www.health.qld.gov.au/hdq/documents/22418\\_3intro.pdf](http://www.health.qld.gov.au/hdq/documents/22418_3intro.pdf)
- Burma, J. (1951). The Background of the Current Situation of Filipino-Americans. *Social Forces*, 30(1), 42-48.
- Burns, R. B., & Burns, R. A. (2008). *Business Research Methods and Statistics Using SPSS* Retrieved 3 Mar 2010 from [http://books.google.com.au/books?id=bPvCRzBou3gC&pg=PA409&dq=validity+and+reliability+test+using+spss&hl=en&ei=EOYoTvbzG8OJmQW3zZGHDA&sa=X&oi=book\\_result&ct=result&resnum=4&ved=0CD8Q6AEwAw#v=onepage&q=validity%20and%20reliability%20test%20using%20spss&f=false](http://books.google.com.au/books?id=bPvCRzBou3gC&pg=PA409&dq=validity+and+reliability+test+using+spss&hl=en&ei=EOYoTvbzG8OJmQW3zZGHDA&sa=X&oi=book_result&ct=result&resnum=4&ved=0CD8Q6AEwAw#v=onepage&q=validity%20and%20reliability%20test%20using%20spss&f=false)
- Cahill, D. (1990). *Intermarriage in the international context: A study of Filipino women married to Australian, Japanese, and Swissmen*. Philippines: Scalabrini Migration Center.
- Cannon, R. (2008). The social determinants of health. *SACCOSS Information Paper*. Retrieved 9 Nov 2010 from [http://www.sacoss.org.au/online\\_docs/081210%20Social%20Determinants%20Health%20Report.pdf](http://www.sacoss.org.au/online_docs/081210%20Social%20Determinants%20Health%20Report.pdf)
- Carballo, M., & Nerukar, A. (2001). Migration, refugees, and health health risks. *International Centre for Migration and Health*, 7(3), 556-560. Retrieved 8 Nov 2009 from [http://www.cdc.gov/ncidod/eid/vol7no3\\_supp/pdf/carballo.pdf](http://www.cdc.gov/ncidod/eid/vol7no3_supp/pdf/carballo.pdf)
- Chin, J. L., & Bigby, J. A. (2003). Care of Asian American. In J. A. Bigby (Ed.), *Cross-cultural medicine: American College of Physician-American Society of Internal Medicine*.

- Chisholm, E. M., Dombal, F. T., & Giles, G. R. (1985). Validation of a self administered questionnaire to elicit gastrointestinal symptoms. *British Medical Journal*, 290.
- Clark, J. (2004). Filipino women in Tasmania: negotiating gender ideologies. *Asian and Pacific Migration Journal*, 13(3), 363-380.
- Cooke, F. M. (1980). Australian-Filipino Marriages in 1980s. The Myth and the Reality. *Australia-Asia Papers*, 37. Retrieved from
- Cornell, S., & Hartmann, D. (1998). *Ethnicity and race: Making identities world*. Thousand Oaks, California: Pine Forge Press.
- Corvalan, C. F., Gopalan, H. N. B., & Llanso, P. (2003). Conclusion and recommendations for action. In A. J. McMichael, D. Campbell-Lendrum, C. F. Corvalan, K. L. Ebi, A. K. Githeko, J. D. Scheraga & A. Woodward (Eds.), *Climate change and human health: risk and responses* (pp. 267-284): World Health Organization.
- Council, M. (2007). *What is health and wellbeing and how it is planned for by Monash council?* Monash City: Monash City Council Retrieved 8 Jun 2010 from <http://www.monash.vic.gov.au/publications/hplan4.htm>.
- Courtright, C. (2004). Health information-seeking among Latino newcomers: an exploratory study. 10(2), paper 224. Retrieved 9 Nov 2009 from <http://Informationr.net/ir/10-2/paper224.html>
- Courtright, C. (2005). Health information-seeking among Latino newcomers: an exploratory study. *iRinformation research*, 10(2), 1-13.
- Cousin, G. (2009). *Researching learning in higher education: An introduction to contemporary methods and approaches*. Routledge, New York: Hoboken.
- Coward, R. (1993). The myth of alternative health. In A. Beattie, M. Gott, L. Jones & M. Sidell (Eds.), *Health and wellbeing: a reader*: McMillan Press Ltd.

- Creswell, Plano Clark, Gutmann, & Hanson. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209-239). Thousand Oaks, California: sage Publications Inc.
- Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*: Sage Publication Inc.
- Cunneen, C., & Stubbs, J. (1996). Violence against Filipino women in Australia: Race, class and gender. Retrieved 10 Oct 2009 from [http://www2.waikato.ac.nz/law/wlr/special\\_1996/5\\_cunneenstubbs.html](http://www2.waikato.ac.nz/law/wlr/special_1996/5_cunneenstubbs.html)
- Davey-Smith, G. (2000). Learning to live with complexity: Ethnicity, socioeconomic position, and health in Britain and the United States. *American Journal of Public Health*, 90, 1964-1998.
- Davies, A. A., Basten, A., & Frattini, C. (n.d.). Migration: A social determinant of migrant's health. *Eurohealth*, 16(1), 10-12. Retrieved 9 Nov 2009 from [http://www2.lse.ac.uk/LSEHealthAndSocialCare/LSEHealth/pdf/eurohealth/Vol16No1/Davies\\_Basten.pdf](http://www2.lse.ac.uk/LSEHealthAndSocialCare/LSEHealth/pdf/eurohealth/Vol16No1/Davies_Basten.pdf)
- De Vaus, D. A. (1993). *Surveys in Social Research* (3rd ed.). London: UCL Press
- Department of Foreign Affairs. (2006). Philippine migration to Australia. *Humanities and Social Sciences*. Retrieved 6 Mar 2010 from <http://www.latrobe.edu.au/pasc/did-you-know.html>
- Department of Immigration and Citizenship. (2009). Migration Program Statistics Retrieved 30 Aug 2008, from <http://www.immi.gov.au/media/statistics/statistical-info/visa-grants/migrant.htm>
- Dolan, R. E. (1991). Philippines a country study. *The Role and Status of Women* Retrieved 7 Aug 2008, from <http://countrystudies.us/philippines/44.htm>

- Easteal, P. (1996). Double Jeopardy : Violence against immigrant women in the home. reports on a study investigating the particular problems faced by immigrant women in violent relationships. *Family Matters*, 45. Retrieved 9 Oct 2009 from <http://www.aifs.gov.au/institute/pubs/fm/fm45pe.pdf>
- Eckersley, R. (2001). Culture, health and wellbeing. In R. Eckersley, J. Dixon & B. Douglas (Eds.), *The social origins of health and wellbeing*: Cambridge University Press.
- Eckersley, R. M. (2007). Culture, Spirituality, Religion and Health: Looking at the big picture. *The Medical Journal of Australia eMJA*, 186(10), 54-56. Retrieved 25 Apr 2010 from [http://www.mja.com.au/public/issues/186\\_10\\_210507/eck11061\\_fm.html](http://www.mja.com.au/public/issues/186_10_210507/eck11061_fm.html)
- Edwards, R. W. ( 2004). Information Paper: Measuring Social Capital: An Australian Framework and Indicators. *Australian Bureau of Statistics, cat. no. 1378.0*. Retrieved 24 Aug 2010 from [http://www.ausstats.abs.gov.au/ausstats/free.nsf/0/13C0688F6B98DD45CA256E360077D526/\\$File/13780\\_2004.pdf](http://www.ausstats.abs.gov.au/ausstats/free.nsf/0/13C0688F6B98DD45CA256E360077D526/$File/13780_2004.pdf)
- Eshiett, M., & Parry, E. (2003). Migrants nad health: a cultural dilemma. *Clinical Medicine, Juornal of the Royal College of Physicians*, 3(3), 229-231. Retrieved 2 Dec 2010 from <http://www.ingentaconnect.com/content/rcop/cm/2003/00000003/art00010>
- Eve. (2008). Russian women and intercultural marriages. *RussianWomenMagazine.com*.
- Farrales, L. L., & Chapman, G. E. (1999). Filipino women living in Canada: Constructing meanings of body, food and health. *Health Care for Women International*, 20(2), 179-194. Retrieved 10 Feb 2011 from <http://www.informaworld.com/smpp/content~db=all+713852391>

- Felce, & Perry. (1995). Quality of life: its definition and measurement in research. *Research in Developmental Disabilities, 16*(1), 51-74.
- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigour using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5*(1), 80-92.
- Fernandez, A. (2001). Health Concerns of Filipino Migrant Workers in Malaysia  
Retrieved 16 Mar 2009, from  
<http://www.ipsnews.net/migration/philippines/aegile.html>
- Fielding, N. G., & Fielding, J. L. (1986). *Linking data*. Newbury Park, CA: Sage.
- FILOPAGES. (2008). *Filipino Australian Business Directory - Linking Filipinos Across Australia*: Filipino Australian Business Directory
- Flores, G. (2006). Language barriers to health care in United States. *The New England Journal of Medicine, 355*(3), 229-231.
- Flores, G., & Vega, L. R. (1998). Barriers to health care access for Latino children: A review. *Family Medicine, 30*(3), 196-205. Retrieved 3 Mar 2009 from  
<http://www.stfm.org/fmhub/Fullpdf/march98/CIIMH2.pdf>
- Foster, J. J. (1998). *Data analysis using SPSS for windows: a beginner's guide*. London; Thousand Oaks, California: Sage Publication.
- Ghent, A. (2008). Overcoming migrant's barrier to health. *Bulletin of the World Health Organization, 86*(8), 583-584. Retrieved 18 May 2010 from  
<http://www.who.int/bulletin/volumes/86/8/08-020808.pdf>
- Giger, J. N., & Davidhizar, R. E. (2004). *Transcultural nursing: Assessment and intervention* (4th ed.): Elsevier Health Sciences.
- Grbich, C. (1999). *Qualitative research in health: an introduction*: Allen and Unwin Pty Ltd.

- Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, 11, 255-274.
- Guanipa, C. (1998). Culture Shock Retrieved 20 Nov 2007, from <http://edweb.sdsu.edu/people/CGuanipa/cultshok.htm>
- Gupta, R. (2006). Acculturation and marital problems among South Asian immigrants. *Clinical Gerontologist*, 29(1), 71-77. Retrieved 4 Dec 2010 from [http://dx.doi.org/10.1300/J018v29n01\\_06](http://dx.doi.org/10.1300/J018v29n01_06) doi:10.1300/J018v29n01\_06
- Gushulak, B. D., & MacPherson, D. W. (2006). *Migration, medicine and health: Principles and practice*: BC Decker Inc.
- Haines, A., Kovats, R. S., Campbell-Lendrum, D., & Corvalan, C. (2006). Climate change and human health: Impacts, vulnerability, and mitigation. *The Lancet*, 367(9528). Retrieved 16 Nov 2010 from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68933-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68933-2/fulltext) doi:10.1016/S0140-6736(06)68933-2
- Halliday, M. A. K. (1994). *An Introduction Functional Grammar* (2nd ed.). London: Edward Arnold.
- Hancock, B. (1998, 2002). Trent Focus for Research and Development in Primary Health Care
- An Introduction to Qualitative Research Retrieved 5 Jul 2008, from [www.trentdsu.org.uk/cms/uploads/Qualitative%20Research.pdf](http://www.trentdsu.org.uk/cms/uploads/Qualitative%20Research.pdf)
- Hardon, A., Boonmongkon, P., Streefland, P., Tan, M. L., Hongvivatana, T., van der Geest, S., . . . Gerrits, T. (2001). *Applied health research manual: Anthropology of health and health care* (Third revised ed.). Amsterdam, The Netherlands: Het Spinhuis Publishers.

- Hautman, J. (2005). The motivation behind your lack of self-acceptance. *Self-creation.com*. Retrieved 9 Feb 2011 from <http://www.selfcreation.com/acceptance/index.htm>
- Health Education Unit, W. (1993). Lifestyle and health. In A. Beattie, M. Gott, L. Jones & M. Sidell (Eds.), *Health and wellbeing: A reader*: McMillan Press Ltd.
- Hoang, H. (2008). *A cross-cultural study of the views and attitudes towards maternity care held by migrants in rural Tasmania*. Master of Medical Science, University of Tasmania, launceston.
- Homan, R. (1991). *The ethics of social research*: Longman Ltd.
- HOOAH 4 HEALTH. (2007). What is wellbeing? Retrieved 9 Aug 2008, from <http://www.hooah4health.com/overview/wellbeing/wellbeing.htm>
- Hosler, D., & Vesper, N. (1993). Anexploratory study of the factors associated with parental savings for postsecondary education. *Journal of Higher Education*, 64(2), 140-165.
- Huff, R. M., & Kline, M. V. (1999). Health promotion in the context of culture. In R. M. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 3-23). Thousand Oaks, California: Sage Publishing, Inc.
- Hugo, G. (2005). Migrants in society: diversity and cohesion: Global Commission on International Migration (GCIM).
- Hunt, C., & Coller, R. (1957). Inter marriage and cultural change: The Philippine American Marriages. *Social Forces*, 223-230.
- Hunt, D. D., & Gatbonton, A. (2000). *Filipino Women and Sexual Violence: Speaking out and providing services*. Paper presented at the Sexual Violence in a Gender, Cultural and Human Rights Framework. Retrieved 7 Oct 2009 from

<http://www.iwss.org.au/public/forumpapers/philippines.pdf> or  
<http://cpcabrisbane.org/CPCA/IWSSForum.htm>

- Inouye, J. (1999). Asian American health and disease: An overview of the issues. In R. M. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 337-356). Thousand Oaks, California: Sage Publications, Inc.
- IOM. (2004). *Psychosocial and mental wellbeing of migrants*. Paper presented at the Seminar on Health and Migration. Retrieved 8 April 2010 from [http://www.iom.int/jahia/webday/site/mayjahiasite/shared/shared/mainsite/microsites/IDM/workshops/Health\\_and\\_Migration\\_09110604/se2\\_conf\\_investing.pdf](http://www.iom.int/jahia/webday/site/mayjahiasite/shared/shared/mainsite/microsites/IDM/workshops/Health_and_Migration_09110604/se2_conf_investing.pdf)
- Irwin, T. (1959). Weather changes. *Popular Science*, 175, 118-121.
- Jabar, M. A. (2006). Battlegrounds of marriage: Conflict experiences of Filipino wives in intercultural marriages. *Graduate Journal of Social Science*, 3(2), 43-57.
- Jang, M., Lee, E., & Woo, K. (1998). Income, language and citizenship status: factors affecting the health care access and utilization of Chinese Americans. *Health and Social Work*, 23. Retrieved 26 Jun 2010 from <http://www.questia.com/googleScholar.qst?docId=5001345628>
- Jehobo, D. (2001). *Quality of life after migration to Australia: A Comparative study of Vietnamese and Filipino migrants*. Bachelor of Science Psychology (Honours), Victoria University, Victoria.
- Jenkins, C. N. H., Le, T., McPhee, S. J., Stewart, S., & Ha, N. T. (1999). Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers? . *Social Science and Medicine*, 43(7), 1049-1056. Retrieved 8 Mar 2009 from [http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6VBF-3VV40XF-2&\\_user=10&\\_coverDate=10%2F31%2F1996&\\_rdoc=1&\\_fmt=high&\\_orig=](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-3VV40XF-2&_user=10&_coverDate=10%2F31%2F1996&_rdoc=1&_fmt=high&_orig=)



[search& sort=d& docanchor=&view=c& searchStrId=1394466675& rerunOrigin=scholar.google& acct=C000050221& version=1& urlVersion=0& u serid=10&md5=75757486c30b0366ba0a6cd2fe04ad6c](http://search& sort=d& docanchor=&view=c& searchStrId=1394466675& rerunOrigin=scholar.google& acct=C000050221& version=1& urlVersion=0& u serid=10&md5=75757486c30b0366ba0a6cd2fe04ad6c)

Jirojwong, S., & Manderson, L. (2001). Feelings of sadness: Migration and subjective assessment of mental health among Thai women in Brisbane Australia. *Transcultural Psychiatry*, 38(2), 167-186.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: a research paradigm whose time has come. *Educational Researcher*, 33(7), 14-26.  
Retrieved 28 Sep 2009 from  
[http://www.aera.net/uploadedFiles/Journals\\_and\\_Publication/Journals/Educational\\_Researcher/Volume\\_33\\_No\\_7/03ERv33n7\\_Johnson.pdf](http://www.aera.net/uploadedFiles/Journals_and_Publication/Journals/Educational_Researcher/Volume_33_No_7/03ERv33n7_Johnson.pdf)

Jones, S. (1985). 'Depth interviewing'. In R. Walker (Ed.), *Applied quantitative research* (pp. 45-55). Aldershot: Gower.

Kagawa-Singer, M., & Maxwell, A. E. (1999). Breast cancer screening in Asian and Pacific Islander American Women. In D. E. Weiner (Ed.), *Preventing and controlling cancer in North America: A cross-cultural perspective* (pp. 147-164). Westport, CT: Praeger Publishers.

Kelaher, M., Williams, G., & Manderson, L. (2001). Population Characteristics, Health and Social Issues among Filipinas in Queensland. *Journal of Ethnic and Migration Studies*, 27.

Khoo, S. (n.d.). Intermarriage, integration and multiculturalism: A demographic perspective. 101-119. Retrieved 12 Mar 2009 from  
<http://epress.anu.edu.au/multiculturalism/pdf/ch06.pdf>

Kimmel, A. J. (1996). *Ethical issues in behavioral research*. Massachusetts: Blackwell Publisher Inc.

Kirk, J., & Miller, M. L. (1986). Reliability and validity in qualitative research  
Retrieved 6 Sep 2010 from

[http://books.google.com.au/books?id=YDFZlq\\_KM88C&printsec=frontcover&dq=reliability+in+qualitative+method&hl=en&ei=4gBCToelL4LprQfg2dTRBw&sa=X&oi=book\\_result&ct=result&resnum=1&ved=0CCsQ6AEwAA#v=onepage&q=reliability%20in%20qualitative%20method&f=false](http://books.google.com.au/books?id=YDFZlq_KM88C&printsec=frontcover&dq=reliability+in+qualitative+method&hl=en&ei=4gBCToelL4LprQfg2dTRBw&sa=X&oi=book_result&ct=result&resnum=1&ved=0CCsQ6AEwAA#v=onepage&q=reliability%20in%20qualitative%20method&f=false)

Kittler, P. G., & Sucher, K. (2008). Southeast Asian and Pacific Islander. In P. G. Kittler & K. Sucher (Eds.), *Food and Culture* (5th ed., pp. 361-406). Belmont, CA: Thompson Learning, Inc.

Knoll, N., & Schwarzer, R. (n.d.) Gender and age differences in social support: A study of East German migrants. Retrieved 9 Oct 2010 from [http://userpage.fu-berlin.de/~health/support/knoll\\_schwarzer\\_in\\_weidner.pdf](http://userpage.fu-berlin.de/~health/support/knoll_schwarzer_in_weidner.pdf)

Knox, D., & Schacht, C. (2010). Choices in relationship: An introduction to marriage and family Retrieved 9 Feb 2011 from [http://books.google.com.au/books?id=x8NT2lMAcJwC&pg=PA230&dq=what+is+interracial+marriages&hl=en&ei=u59TZOrA4ikuAOzhN3fBw&sa=X&oi=book\\_result&ct=result&resnum=2&ved=0CDIQ6AEwATgK#v=onepage&q=what%20is%20interracial%20marriages&f=false](http://books.google.com.au/books?id=x8NT2lMAcJwC&pg=PA230&dq=what+is+interracial+marriages&hl=en&ei=u59TZOrA4ikuAOzhN3fBw&sa=X&oi=book_result&ct=result&resnum=2&ved=0CDIQ6AEwATgK#v=onepage&q=what%20is%20interracial%20marriages&f=false)

Kristiansen, M., Mygind, A., & Krasnik, A. (2007). Health effects of migration. *Danish Medical Bulletin*, 54(1), 46-47. Retrieved 25 Oct 2010 from [http://www.danmedbul.dk/DMB\\_2007/0107/0107-artikler/DMB3871.pdf](http://www.danmedbul.dk/DMB_2007/0107/0107-artikler/DMB3871.pdf)

Kumar, R. (1996). *Research Methodology: A step-by-step guide for beginners* Longman Australia Pty Limited.

Kumar, R. (2010). *Research methodology: A step-by-step guide for beginners* (3rd ed.): Sage Publications Ltd.

Lassiter, S. M. (1995). Multicultural clients: A professional handbook for health care providers and social workers Retrieved 19 Oct 2009 from <http://books.google.com.au/books?hl=en&lr=&id=0HzoNfy->

[EC&oi=fnd&pg=PR7&dq=filipino+health+beliefs+and+practices&ots=0sd1tdbEsS&sig=LNOnpTbutW\\_DuKP842I06Vp8PTw#v=onepage&q&f=false](#)

Latrobe University. (2006). Philippine Migration to Australia, 2008,. Retrieved 29 Oct 2009 from <http://www.latrobe.edu.au/pasc/did-you-know.html>

Le, & Le, T. (2005). *Cultural attitudes of Vietnamese Migrants on Health Issues*. Paper presented at the AARE.

Le, M. (1999). Miscommunication: From intracultural to intercultural socialisation. Retrieved 23 Oct 2009 from <http://www.educ.utas.edu.au/users/tle/JOURNAL/Articles/Le/Le.html>

Le, T. (2007). [Interracial marriage seminar].

Ledogar, R. J., & Fleming, J. (2008). Social capital and resilience: A review of concepts and selected literature relevant to Aboriginal youth resilience research *Pimatisiwin*, 6(2), 25-46. Retrieved 12 Nov 2010 from <http://www.ncbi.nih.gov/pmc/articles/PMC2956751/pdf/nihms761.pdf>

Lee, S. M., & Pacheco, G. (2003). Culture and health: A case study of foreign-born Asian women's health beliefs, values, and experiences Retrieved 17 Mar 2009, from [http://www.allacademic.com//metap/p\\_mla\\_apa\\_research\\_citation/1/0/7/1/8/pages107187/p107187-1.php](http://www.allacademic.com//metap/p_mla_apa_research_citation/1/0/7/1/8/pages107187/p107187-1.php)

Legge, V. (1981). *Migrants and Health*. Sydney: Cumberland College of Health Science.

Lincon, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lloyd, D., Newell, S., & Dietrich, U. C. (2004). Health inequity: A review of the literature. *School of Education Papers*. Retrieved 8 Sep 2009 from [http://epubs.scu.edu.au/cgi/viewcontent.cgi?article=1136&context=educ\\_pubs](http://epubs.scu.edu.au/cgi/viewcontent.cgi?article=1136&context=educ_pubs)

- Longman, A. W., & Kumar, R. (1996). *Research methodology: A step-by-step guide for beginners*: Australia Pty Limited.
- Ludwig-Beymer, P. (2008). Creating culturally competent organizations. In M. M. Andrews & J. S. Boyle (Eds.), *Transcultural concepts in nursing care* (5th ed., pp. 197-225): Wolters Kluwer | Lippincott Williams & Wilkins.
- Lyons, R., & Langille, L. (2000). Healthy Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health *Public Health Agency of Canada*  
Retrieved 9 Dec 2010 from <http://www.phac-aspc.gc.ca/ph-sp/docs/healthy-sain/pdf/lifestyle.pdf>
- Mason, P. (2010). Know the facts about physical health. Retrieved 21 Apr 2011 from [http://books.google.com.au/books?id=nmcc0Cz7tpwC&printsec=frontcover&dq=what+is+physical+health&hl=en&ei=SqTtTcaDJ466vQPX59SSBg&sa=X&oi=book\\_result&ct=result&resnum=6&ved=0CEwQ6AEwBQ#v=onepage&q=what%20is%20physical%20health&f=false](http://books.google.com.au/books?id=nmcc0Cz7tpwC&printsec=frontcover&dq=what+is+physical+health&hl=en&ei=SqTtTcaDJ466vQPX59SSBg&sa=X&oi=book_result&ct=result&resnum=6&ved=0CEwQ6AEwBQ#v=onepage&q=what%20is%20physical%20health&f=false)
- Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Education Review*, 62, 279-299.
- McAllister, F. (2005). Wellbeing concepts and challenges. Retrieved 13 Aug 2009 from [http://sdrnadmin.rechord.com/wp-content/uploads/sdrnwellbeingpaper-final\\_000.pdf](http://sdrnadmin.rechord.com/wp-content/uploads/sdrnwellbeingpaper-final_000.pdf)
- McBride, M. (n.d.). Health and health care of Filipino American elders. In S. Stanford University School of Medicine, California (Ed.), *Stanford Geriatric Education Center*.
- McIver, J. P., & Carmines, E. G. (1981). *Unidimensional scaling*. Thousand Oaks, CA: Sage.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd edition ed.). Thousand Oaks, CA: Sage.

- Miller-deBerard, L. (2006). Solutions to Common Marital Problems. Retrieved 5 Oct 2009 from <http://www.ccpccounseling.com/images/solutions.pdf>
- Miller, W., & Crabtree, B. F. (1992). Primary care research: A multimethod typology and qualitative road map. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research: Research methods for primary care* (Vol. 3). Newbury Park, CA: Sage.
- Mitchell, H., Bullard, J., & Mudd, E. (1962). Areas of marital conflict in successfully and unsuccessfully functioning families. *Journal of Health and Human Behaviour*, 3(2), 88-93.
- Morse, J. M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing research*, 40, 120-123.
- Mowatt, J., & Wall, D. (1992). *Dealing with the media-Filipino Women in cross-cultural marriages*. NSW: Filipino Women working Party.
- Multicultural Council Tasmania Inc. (n.d.). Multicultural Council Tasmania Inc. - General Information Retrieved 24 April 2008, from <http://www.mcot.org.au/organisations.htm>
- Mulvihill, M. A., Mailloux, L., & Atkin, W. (2002). *Advancing Policy and research responses to immigrant and refugee women's health in Canada*. Ottawa: Women's Health Bureau and the Research Management and Dissemination Division, Health Canada.
- Murray, T. R. (2003). *Blending qualitative and quantitative research methods in theses and dissertations*. Thousand Oaks, California: Corwin Press, Inc.
- n.a. (2006a). Cultural awareness. *Centre for Cultural Diversity in Ageing*. Retrieved 6 Dec 2009 from <http://www.culturaldiversity.com.au/NationalResources/ServiceProviderResources/CulturalAwareness.aspx>

- n.a. (2006b). *Living in Australia*. Retrieved 30 Sep 2009 from  
<http://www.immi.gov.au/living-in-australia/settle-in-australia/everyday-life/health/index.htm>
- n.a. (2009a). Health Care. *US History Encyclopedia*. Retrieved 5 Sep 2009 from  
<http://www.answers.com/health-care&r=67>
- n.a. (Ed.) (2009b) Babylon Free Dictionary. Babylon, Inc.
- Nadal, K. L. (2009). *Filipino American Pshychology: A handbook of theory, research and clinical practice*. Bloomington, IN: Amber House.
- National Statistics Office. (2006). *More females opt to be May brides (Marriage statistics, Philippines 2003)*. (206). Manila: National Statistics Office  
 Retrieved 19 Aug 2009 from  
<http://www.census.gov.ph/data/sectordata/sr06206tx.html>.
- Natividad, G. Q. (2008). Barriers to tuberculosis screening among Filipino immigrants to the United States. In M. de Chesnay & B. A. Anderson (Eds.), *Caring for the vulnerable: Perspectives in nursing theory, practice, and research* (2nd ed., pp. 321-334): Jones and Bartlett Publishers, Inc.
- Nau, D. (1995). Mixing Methodologies: Can Bimodal Research be a Viable Post-Positivist Tool? . *The Qualitative Report The Qualitative Report [On-line serial]*, 2(3).
- Newman, I., Ridenour, C. S., Newman, C., & DeMarco, G. M. (2003). A typology of research purposes and its relationship to mixed methods. In A. Tashakkori & C. Teddlie (Eds.), *Handbook in Mixed Methods in Social and Behavioral Research* (pp. 167-188). Thousand Oaks, California: Sage Publication Inc.
- Newton, J. (2007). Wellbeing and the natural environment: A brief overview of the evidence. Retrieved from Julie%20Newton%20Paper[1].pdf
- Ng, E., & Omariba, D. W. R. (2010). Health literacy and immigrants in Canada: Determinants and effects on health outcomes. *Health Analysis Division*,

Statistics Canada. Retrieved 16 May 2011 from [http://www.ccl-cca.ca/pdfs/OtherReports/NgOmaribaHealthLiteracyImmigrantsExSum\\_EN.pdf](http://www.ccl-cca.ca/pdfs/OtherReports/NgOmaribaHealthLiteracyImmigrantsExSum_EN.pdf)

Ngo-Metzger, Q., massagli, M. P., Clarridge, B. R., Manocchia, M., Davis, R. B., Irzzoni, L. I., & Phillips, R. S. (2007). Linguistic and cultural barriers to care. *Journal of General Internal Medicine*, 18(1), 45-52.

Nightingale, F. (1859). *Notes on nursing: What it is, and what it is not?* (Commemmorative ed.). Philadelphia: Lippincott.

Norredam, M. L., Nielsen, A. S., & Krasnik, A. (2007). Migrants access to healthcare. *Danish Medical Bulletin*, 54(1), 48-49. Retrieved 12 Oct 2009 from [http://www.danmedbul.dk/DMB\\_2007/0107/0107-artikler/DMB3869.htm](http://www.danmedbul.dk/DMB_2007/0107/0107-artikler/DMB3869.htm)

NSO. (2007). *Foreign marriages of the Filipinos*. Manila, Philippines: Retrieved from <http://www.census.gov.ph/data/sectordata/sr11566tx.html>.

Nutbeam, D. (2001). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15(3), 259-267.

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validity issues in mixed research. *Mid-South Educational Research Association*, 13(1), 48-63.

Oppenheim, A. N. (1992). *Questionnaire design, interviewing and attitude measurement* London: Pinter Publishers Ltd.

Palmer, G. R., & Short, S. D. (2000). *Health care and public policy: An Australian Analysis* (Third ed.): Palgrave Macmillan Australia.

Patz, J. A., Engelberg, D., & Last, J. (2000). The effects of changing weather on public health. *Annual Review of Public Health*, 21, 271-307. Retrieved 8 Feb 2010 from <http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.21.1.271> doi:10.1146/annurev.publhealth.21.1.271

- Pedersen, P. (1995). *The five stages of culture shock: critical incidents around the world*. Westport, CT: Greenwood Publishing Group Ltd.
- Periyakoil, V. J., & Dela Cruz, M. T. (2010). Health and health care of Filipino American Older Adults In V. S. Periyakoil (Ed.), *eCampus-Geriatrics*. Stanford, CA.
- Pink, B. (2008). Social participation of migrants. *Australian Bureau of Statistics: Australian Social Trends*, 4102.0. Retrieved 20 Oct 2010 from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/B9F416D2C7714D46CA25748E00123451?opendocument>
- Pobutsky, A. M., Buenconsejo-Lum, L., Chow, C., Palafox, N., & Maskarinec, G. G. (2005). Micronesian Migrants in Hawaii: Health issues and Culturally appropriate, community-based solutions. *Californian Journal of Health Promotion*, 3(4), 59-72. Retrieved 24 Jan 2009 from <http://www.csuchico.edu/cjhp/3/4/59-72-pobutsky.pdf>
- Portes, P. R. (1996). Ethnicity in education and psychology. In D. Belinger & R. Calfee (Eds.), *The handbook of educational psychology* (pp. 331-358). New York: Macmillan.
- Pottie, K. (2007). Language proficiency, recent immigrants, and global health disparities. *Canada Family Physician*, 53(11), 1899-1901.
- PR Newswire. (2009). Census bureau news facts for features Asian/Pacific American Heritage Month: May 2009 Retrieved 18 July 2011, from <http://news.prnewswire.com/ViewContent.aspx?ACCT=109&STORY=/www/story/04-23-2009/0005011935&EDATE=>
- Punch, K. F. (1998). *Introduction to Social Researcher: Quantitative and Qualitative Approaches*. London; Thousand Oaks, CA: Sage Publication Ltd.
- Punch, K. F. (2005). *Introduction to social research: quantitative and qualitative approaches* (2nd ed.). Thousand Oaks, California: Sage Publications Inc.



- Rawlings-Way, C., Worby, M., & Mocatta, G. (2008). Tasmania Retrieved 16 Nov 2010 from [http://books.google.com.au/books?id=g4y3BMtG5W8C&dq=health+care+i+n+tasmania&source=gb\\_s\\_navlinks\\_s](http://books.google.com.au/books?id=g4y3BMtG5W8C&dq=health+care+i+n+tasmania&source=gb_s_navlinks_s)
- Reyes, B. (Producer). (2007). How Filipino brides are changing the DNA of several nationalities and also the Filipino. Retrieved 28 May 2010 from <http://www.mabuhayradio.com/women-s-section/how-filipino-brides-are-changing-the-dna-of-several-nationalities-and-also-the-filipino>
- Reyes, V. (2006). *Filipina Military Brides: Negotiating Assimilation and Cultural Maintainance within a Bicultural Setting*. Ohio State University. Retrieved from [https://kb.osu.edu/dspace/bitstream/1811/6542/1/vicky\\_thesis.pdf](https://kb.osu.edu/dspace/bitstream/1811/6542/1/vicky_thesis.pdf)
- Reynolds, P. D. (1979). *Ethical Dilemmas and Social Science Research: An analysis of moral issues confronting investigators in research using human participants*. San Francisco: Jossey-Bass.
- Rice, P., & Ezzy, D. (1999). *Qualitative research methods: A health focuc*. Melbourne: Oxford University Press.
- Rispens-Noel, L. (1997). Philippine International Migration: Issues and Concern of Filipino Migrants in the Netherlands - A Summary Retrieved 16 Mar 2009, from <http://www.philsol.nl/fora/FFON97-summary.htm>
- Root, M. P. P. (2001). *Love's revolution: interracial marriage*. Philadelphia: Temple University Press.
- Rosa, A., & Mo, J. J. (2009). Filipino American food practices. In C. M. Goody & L. Drago (Eds.), *Cultural food practices: Diabetes Care and Education Dietic Practice Group: American Dietic Association Health and Fitness*.
- Rosaldo, M. (1980). *Knowledge and passion: Ilongot notions of self and social life*. Cambridge, UK: Cambridge University Press.

- Roxon, N. (2009). *Development of a new National Women's Health Policy Consultation Discussion Paper 2009*. Woden, ACT: Australian Government; Department of Health and Aging. Retrieved 16 Jul 2010 from <http://www.health.gov.au/internet/main/publishing.nsf/Content/whdp-09~whdp-09-intro>.
- Ruebhausen, O. M., & Brim, O. G., Jr. (1966). Privacy and behavioral Research. *American Psychologist*, 21, 423-437.
- Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: a review of research on hedonic and eudaimonic wellbeing. *Annual Review of Psychology*, 52, 141-166.
- Salcedo, L. L., Peralta, A. M. R., Ronquillo, A. A., & Espiritu, S. C. (1999). Social issues Retrieved 19 Oct 2010 from [http://books.google.com.au/books?id=8D--TmX2sqsc&pg=PA62&dq=the+care+of+filipino+family&hl=en&ei=Y1zcTdLdD5CougOznomfDw&sa=X&oi=book\\_result&ct=result&resnum=1&ved=0CDcQ6AEwAA#v=onepage&q=the%20care%20of%20filipino%20family&f=false](http://books.google.com.au/books?id=8D--TmX2sqsc&pg=PA62&dq=the+care+of+filipino+family&hl=en&ei=Y1zcTdLdD5CougOznomfDw&sa=X&oi=book_result&ct=result&resnum=1&ved=0CDcQ6AEwAA#v=onepage&q=the%20care%20of%20filipino%20family&f=false)
- Samonte, E. (1986). *Filipino wives with Japanese husbands: Communication variables and marital satisfaction*. Master's thesis, University of the Philippines, Quezon City.
- Sanchez, F., & Gaw, A. (2007). Mental health care of Filipino Americans. *American Psychiatric Association*, 58, 810-815.
- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16, 1-8.
- Sandhu, D. S. (1997). Psychocultural profiles of Asian and Pacific Islander Americans: Implications for counseling and psychotherapy *Journal of Multicultural Counseling and Development*, 25(1), 1-12.

- Saroca, C. (2002). Hearing the voices of Filipino women: Violence, media representation and contested realities Retrieved 4 Mar 2009, from <http://rspas.anu.edu/anthropology/intermarriage/philippines.php>
- Saroca, C. (2006). Filipino Women, Migration, and Violence in Australia: Lived Reality and Media Image. *Kasarinlan: Philippine Journal of Third World Studies*, 21(1), 75-110.
- Schmitz, P. G. (2003). Individual Differences in Acculturative Stress Reactions: Determinants of Homesickness and Psychosocial Maladjustment Retrieved 9 Apr 2008, from <http://spitswww.uvt.nl/web/fsw/psychologie/emotions2003/1/word-h7.Schmitz.pdf><http://spitswww.uvt.nl/web/fsw/psychologie/emotions2003/1/word-h7.Schmitz.pdf>
- Schneider, D. J. (2004). *The psychology of stereotyping*. New York, NY: The Guilford Press.
- Schyve, P. M. (2007). Language Differences as a Barrier to Quality and Safety in Health Care: The Joint Commission Perspective. *Journal of General Internal Medicine*, 22(2), 360-361. Retrieved 12 Mar 2010 from <http://www.springerlink.com/content/k477nn57w37u2062/fulltext.pdf>
- Semics LLC. (2007). Culture and health among Filipinos and Filipino-Americans in Central Los Angeles. 1-91. Retrieved from [http://www.esipa.org/happening/documents/Culture\\_Health\\_Report.pdf](http://www.esipa.org/happening/documents/Culture_Health_Report.pdf)
- Shah, H., & Marks, N. (2004). A well-being manifesto for a flourishing society. *nef (the new economics foundation)*. Retrieved 17 Sept 2010 from [http://www.wellbeingmanifesto.net/uk\\_manifesto.pdf](http://www.wellbeingmanifesto.net/uk_manifesto.pdf)
- Shapiro, M. E. (2002). Asian culture brief: Philippines. *NTAC-AAPI and the Center for International Rehabilitation Research Information and Exchange (CIRRIE)*, 2(3). Retrieved 25 Oct 2009 from

<http://www.ntac.hawaii.edu/downloads/products/briefs/culture/pdf/ACB-Vol12-Iss3-Philippines.pdf>

- Shepard, L. A. (1979). Self-acceptance: The evaluative component of the self-concept construct. *American Educational Research Journal*, 16(2), 139-160.
- Simon, S. (1999). Stats: Designing a pilot study. Retrieved 6 Mar 2008 from <http://www.childrens-mercy.org/stats/plan/pilot.asp>
- Smith. (2004). *Australia's Rural and Remote Health: a social justice perspective*. Croydon, Victoria: Tertiary Press.
- South Eastern Region Migrant Resource Centre. (2010, June 1, 2011). Filipino Cultural Profile - older people Retrieved 30 Aug 2009, from [http://www.sermrc.org.au/uploads/mrc\\_resources/Filipino%20Cultural%20Profile%2021-06-10.pdf](http://www.sermrc.org.au/uploads/mrc_resources/Filipino%20Cultural%20Profile%2021-06-10.pdf)
- Spardley, J. P. (1979). *The ethnographic interview*. Toronto, ON: Holt, Rinehart and Winston.
- Spector, R. (2004). *Health traditions* (6th ed.). Upper Saddle River, NJ: Prentice Hall.
- Spector, R. E. (2000). *Cultural diversity in health and illness* (5th ed.). Upper Saddle River: NJ: Prentice-Hall Health.
- Spradley, J. P. (1980). *Participant observation*. New York: Holt, Rinehart and Winston.
- Stewart, D. E., & Nam Do, B. (2003). Health needs of migrant Vietnamese in South-Western Brisbane: An exploratory study. *Australian Journal of Social Issues*, 38.
- Tan-Alora, A., & Lumitao, J. M. (2001). An introduction to an authentically non-western bioethics. In A. Tan-Alora & J. M. Lumitao (Eds.), *Beyond a western bioethics: voices from the developing world* (pp. 3-22). Washington, D.C.: Georgetown University Press.

- Taunton, P. E. (n.d.). Qualitative research methods. *RDSU Peninsula Research & Development Unit*.
- Thomas, J., & Harden, A. (2008). Methods for thematic analysis synthesis of qualitative research in systematic reviews. *Journal of Medical Case Reports*, 8(45).
- Thomas, T. N. (1995). Acculturative stress in the adjustment of immigrant families. *Journal of Social Distress and Homeless*, 4(2), 131-142. doi: 10.1007/BF02094613
- Tinker, J. N. (1984). Intermariage and assimilation in a plural society: Japanese-Americans in the United States. In G. A. Cretser & J. J. Leon (Eds.), *Intermarriage in the United States* (pp. 61-74). Binghamton, NY: Haworth Press, Inc.
- Trewin, D. (2001). *4160.0 Measuring wellbeing: Frameworks for Australian Social Statistics, 2001*. Belconnen, ACT: Australian Bureau of Statistics. Retrieved 29 Nov 2010 from <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4160.0Contents12001?opendocument&tabname=Summary&prodno=4160.0&issue=2001&num=&view=>.
- Turner, A. G. (1982). What subjects of survey research believed about confidentiality. In J. E. Sieber (Ed.), *The ethics of social research: Survey and experiments* (pp. 151-165). New York: Springer.
- Uba, L. (1992). Cultural barriers to health care for Southeast Asian Refugees. *Public Health Reports* 107(5), 544-548.
- Ungerleider, C. (2004). The social determinants of health: Education as a determinant of health. *Public Health Agency Canada*. Retrieved 12 Aug 2010 from [http://www.phac-aspc.gc.ca/ph-sp/oi-ar/10\\_education-eng.php](http://www.phac-aspc.gc.ca/ph-sp/oi-ar/10_education-eng.php)

- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London, ON: University of Western Ontario.
- van Teijlingen, E. R., & Hundley, V. (2001). The importance of pilot study Retrieved 28 Jul 2008, from <http://sru.soc.surrey.ac.uk/SRU35.html>
- Videbeck, S. L. (2010). *Psychiatric-mental health nursing* (5th ed.): Lippincott Williams and Wilkins.
- Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S., & Kazanjian, A. (2004). Integrating ethnicity and migration as determinants of canadian women's health. *BMC Women's Health*, 4(1). Retrieved 22 Jun 2010 from <http://www.biomedcentral.com/1472-6874/4/S1/S32> doi:10.1186/1472-6874-4S1-S32
- Weisner, T. S. (1993). Overview of siblings similarity and difference in different cultures. In C. W. Nuckolls (Ed.), *Siblings in South Asia: Brothers and sisters in cultural context*. New York: Guilford.
- Westin, A. F. (1968). *Privacy and freedom*. New York: Atheneum.
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11(4), 522-537. Retrieved 30 Mar 2010 from [http://cmapspublic.ihmc.us/rid=1173699120494\\_1473970327\\_12006/whittemore2001.pdf](http://cmapspublic.ihmc.us/rid=1173699120494_1473970327_12006/whittemore2001.pdf)
- Wilkilson, R. G., & Marmot, M. G. (2003). Social determinants of health: The solid facts
- Woelz-Stirling, N., Manderson, L., Kelaher, M., & Gordon, S. (2000). Marital conflict and finances among Filipinas in Australia. *International Journal of Intercultural Relations*, 24, 791-805.
- Wolf, D. (1997). Family secrets: Transnational struggles among children of Filipino migrants. *Sociological Perspectives*, 40(3), 457-482.

- Wu, T. Y., & Bancroft, J. (2006). Filipino American women's perceptions and Experiences with breast cancer screening. *Oncology Nursing Forum*, 33(4), 71-78. doi: 10.1188/06.ONF.E71-E78
- Yamada, S., Caballero, J., Matsunaga, D. S., Agustin, G., & Magana, M. (1999). Attitudes regarding Tuberculosis in immigrants from the Philippines to the United States. *Family Medicine*, 31(7), 447-482.
- Yancey, G. A., & Lewis, R. (2009). Interracial Families: Current concepts and controversies Retrieved 31 Mar 2010 from [http://books.google.com.au/books?id=UiaiJULj0s8C&pg=PA17&dq=what+is+interracial+marriages&hl=en&ei=u59TZOrA4ikuAOzhN3fBw&sa=X&oi=book\\_result&ct=result&resnum=6&ved=0CEgQ6AEwBTgK#v=onepage&q=what%20is%20interracial%20marriages&f=false](http://books.google.com.au/books?id=UiaiJULj0s8C&pg=PA17&dq=what+is+interracial+marriages&hl=en&ei=u59TZOrA4ikuAOzhN3fBw&sa=X&oi=book_result&ct=result&resnum=6&ved=0CEgQ6AEwBTgK#v=onepage&q=what%20is%20interracial%20marriages&f=false)
- Yeo, Hikoyeda, N., McBride, M., Chin, S.-Y., Edmonds, M., & Hendrix, L. (1998). *Cohort analysis as a tool in ethnogeriatrics: Historical profiles of elders from eight ethnic populations in the United States*. Stanford, CA: Stanford Geriatric Education Center, SGEC Working Paper Series #12.
- Yeo, S. (2004). Language barriers and access to care. In A. M. Villaruel, J. J. Fitzpatrick & C. P. Porter (Eds.), *Annual Review of Nursing Research* (Vol. 22, pp. 59-73). Broadway New York, NY: Springer Publishing Company, Inc.
- Znaniecki, F. (1934). *The method of sociology*. New York: Farrer and Rinehart.

# Appendices

- 1- Ethics application
- 2- Ethics approval
- 3- Publications derived from the thesis



## Social Sciences - Minimal Risk Application Form

An electronic version of Minimal Risk form and attachments must be emailed to  
[Marilyn.Knott@utas.edu.au](mailto:Marilyn.Knott@utas.edu.au)  
 This will accelerate the approval process – send a signed hard copy in the mail.

### **SECTION 1** – Researchers (Note separate section below for Student researchers)

|                                  |  |
|----------------------------------|--|
| <b>Title of Research project</b> | Health and Well-being of Intermarried Filipino Women in Rural Tasmania |
|----------------------------------|--|

|                                  |                                       |
|----------------------------------|---------------------------------------|
| <b>School/Department/Centre:</b> | University Department of Rural Health |
|----------------------------------|---------------------------------------|

|   |                      |
|---|----------------------|
| <b>Chief Investigator/Supervisor:</b><br>(Not the student investigator) | Dr Quynh Le          |
| <b>Phone</b>  | 03 – 6324 4053       |
| <b>Email address</b>  | Quynh.Le@utas.edu.au |
| <b>Signature</b>  |                      |

|                           |                            |
|---------------------------|----------------------------|
| <b>Other Investigator</b> | A/Prof Sue Kilpatrick      |
| <b>Phone</b>              | 03 – 6324 4011             |
| <b>Email address</b>      | Sue.Kilpatrick@utas.edu.au |
| <b>Signature</b>          |                            |

|                           |                  |
|---------------------------|------------------|
| <b>Other Investigator</b> | Dr Thao Le       |
| <b>Phone</b>              | 03 – 6324 3696   |
| <b>Email address</b>      | T.Le@utas.edu.au |
| <b>Signature</b>          |                  |

**STUDENT** Investigator(s)      STUDENT DETAILS MUST BE COMPLETED

| Student Name                                  | Student ID No. | Date of birth   | Honours, PhD etc.  |
|---|----------------|-----------------|--------------------|
| Chona Hannah                                  | 069773         | 08/01/79        | PhD                |
| Student email address:paul.hannah@bigpond.com |                | Phone: 63444637 | Mobile: 0409527234 |

By signing the above, all investigators are confirming the following statements:

1. I confirm that I have read and abide by the principles as explained in the *National Statement on Ethical Conduct Involving Humans* (NH&MRC)
2. That all the following responses are true and accurate.
3. I confirm that all data (video and audio tapes, questionnaires etc) will be kept securely stored during the research, and retained under lock and key in the School to which I belong for a period of at least 5 years after completion of the research. Your School/Institution will have policies in relation to the retention of data.
4. I undertake to use the data and information collected in the research only for the purposes of the research, to make no unauthorised disclosure of that data or information, and to maintain the anonymity of all participant data except pursuant to the express consent of the relevant participant(s).

## SECTION 2 – STATEMENT OF METHODOLOGICAL MERIT

The **Head of School\*** is required to sign the following statement:

This proposal has been considered and is sound with regard to **its merit and methodology**.

The Head of School's (or Head of Discipline's) signature on the application form indicates that:

he/she has read the application and confirms that it is sound with regard to

- (i) educational and/or scientific merit and
- (ii) research design and methodology.

If the Head of School/Discipline is one of the investigators this statement must be signed by an appropriate person. This will normally be the Head of School/Discipline in a related area.

This does not preclude the Committee from questioning the research merit or methodology of any proposed project where it feels it has the expertise to do so.

| Name of Head of School | Signature | Date |
|------------------------|-----------|------|
| A/Prof Sue Kilpatrick  |           |      |

\* Where the Head of School is an investigator, In some schools the signature of the Head of Discipline may be more appropriate. \* An investigator on the project may not give the certification of scientific merit.

## SECTION 3 - DATA STORAGE

|   |  |
|---|--|
| Indicate the School at which the data will be retained. | University Department of Rural Health (UDRH) |
|---|--|

## SECTION 4 - FUNDING

|   | YES | NO                                  |
|---|-----|-------------------------------------|
| Is the research being funded by an agency outside the University? |     | <input checked="" type="checkbox"/> |
| If 'YES' is ticked provide funding/grant details:                 |     |                                     |
|   |     |                                     |

**If 'NO' is ticked, Indicate how and by whom the research will be funded if costs are involved and there is not external funding as above:**

The UDRH will cover for the cost of research expenditure during candidature progress.

## **SECTION 5 - RECRUITMENT**

|   | YES                                 | NO                                  |
|---|-------------------------------------|-------------------------------------|
| Recruitment by advertisement information sessions and/or email. (please append the advertisement if 'yes'),   |                                     | <input checked="" type="checkbox"/> |
| Recruitment by contacting people via their publicly listed email addresses  |                                     | <input checked="" type="checkbox"/> |
| Recruitment via a third party or agency   | <input checked="" type="checkbox"/> |                                     |
| Will the Information Sheets and/or Consent Forms be sent to a contact within that organisation and disseminated there?  | <input checked="" type="checkbox"/> |                                     |
| <p><b>NOTE:</b> Please be aware that <b>under no circumstances</b> must researchers receive a list of names and addresses from third parties or agencies, as this would contravene the Privacy Act 1988 (Cth). Researchers may have their Information Sheet and Consent Forms sent to possible participants through the third parties and agencies. This will allow potential participants to volunteer without any coercion.</p> <p>An Information Sheet needs to be sent to the head of agencies/businesses/associations/clubs etc introducing the research and politely enlisting their help in distributing the Information Sheet and Consent Forms to the intended cohort.</p> |                                     |                                     |
| If your recruitment method is different from that above, please detail below:   |                                     |                                     |
| <p>Apart from recruiting participants via third party or agency, snowball process is also used for participant recruitment. This process starts from an initial state of small significance and builds upon itself, becoming larger. For example, contact is made through a network of close friends who will introduce others.</p>   |                                     |                                     |

## **SECTION 6 - RISK ASSESSMENT**



**A. Are any of the following topics to be covered in part or in whole?**

|   | YES | NO                                  |
|---|-----|-------------------------------------|
| Research about/involving/investigating: |     |                                     |
| Parenting practices                     |     | <input checked="" type="checkbox"/> |
| Sensitive personal issues               |     | <input checked="" type="checkbox"/> |
| Sensitive cultural issues               |     | <input checked="" type="checkbox"/> |
| Grief, death or serious/traumatic loss  |     | <input checked="" type="checkbox"/> |
| Depression, mood states, anxiety        |     | <input checked="" type="checkbox"/> |
| Gambling                                |     | <input checked="" type="checkbox"/> |
| Eating disorders                        |     | <input checked="" type="checkbox"/> |
| Illicit drug taking                     |     | <input checked="" type="checkbox"/> |
| Substance abuse                         |     | <input checked="" type="checkbox"/> |
| Self report of criminal behaviour       |     | <input checked="" type="checkbox"/> |
| Any psychological disorder              |     | <input checked="" type="checkbox"/> |
| Suicide                                 |     | <input checked="" type="checkbox"/> |

|                               |  |                                     |
|-------------------------------|--|-------------------------------------|
| Gender identity               |  | <input checked="" type="checkbox"/> |
| Sexuality                     |  | <input checked="" type="checkbox"/> |
| Race or ethnic identity       |  | <input checked="" type="checkbox"/> |
| Any disease or health problem |  | <input checked="" type="checkbox"/> |
| Fertility                     |  | <input checked="" type="checkbox"/> |
| Termination of pregnancy      |  | <input checked="" type="checkbox"/> |

**B. Are any of the following procedures to be employed?**

|  | YES | NO                                  |
|--|-----|-------------------------------------|
| Use of personal data obtained from Commonwealth or State Government Department/Agency <b>without the consent</b> of the participants e.g. getting a list of addresses from the Australian Electoral Commission |     | <input checked="" type="checkbox"/> |
| If you answered yes, please state which Commonwealth Agency is involved and what information is being sought:  |     |                                     |
|  |     |                                     |

|  | YES | NO                                  |
|--|-----|-------------------------------------|
| Deception of participants                        |     | <input checked="" type="checkbox"/> |
| Concealing the purposes of the research          |     | <input checked="" type="checkbox"/> |
| Covert observation                               |     | <input checked="" type="checkbox"/> |
| Audio or visual recording <b>without consent</b> |     | <input checked="" type="checkbox"/> |

**C. Will any of the following procedures be used on participants?**

|  | YES | NO                                  |
|--|-----|-------------------------------------|
| Withholding from one group specific treatments or methods of learning, from which they may "benefit" (e.g., in medicine or teaching) |     | <input checked="" type="checkbox"/> |
| Any psychological interventions or treatments  |     | <input checked="" type="checkbox"/> |
| Administration of physical stimulation   |     | <input checked="" type="checkbox"/> |
| Invasive physical procedures   |     | <input checked="" type="checkbox"/> |
| Infliction of pain   |     | <input checked="" type="checkbox"/> |
| Administration of drugs  |     | <input checked="" type="checkbox"/> |
| Administration of other substances   |     | <input checked="" type="checkbox"/> |
| Administration of ionising radiation   |     | <input checked="" type="checkbox"/> |
| Tissue sampling or blood taking  |     | <input checked="" type="checkbox"/> |
| Collecting body fluid  |     | <input checked="" type="checkbox"/> |
| Genetic testing  |     | <input checked="" type="checkbox"/> |
| Use of medical records where participants can be identified or linked  |     | <input checked="" type="checkbox"/> |
| Drug trials and other clinical trials  |     | <input checked="" type="checkbox"/> |
| Administration of drugs or placebos  |     | <input checked="" type="checkbox"/> |

**D. Other Risks**

|   | YES | NO                                  |
|---|-----|-------------------------------------|
| Any risks to researcher, (eg. research undertaken in unsafe environments or trouble spots)? |     | <input checked="" type="checkbox"/> |

## SECTION 7 - PARTICIPANTS - VULNERABILITY ASSESSMENT

A. Do any of the participants fall within the following targeted categories?

|  | YES | NO                                  |
|--|-----|-------------------------------------|
| Suffering a psychological disorder   |     | <input checked="" type="checkbox"/> |
| Suffering a physical vulnerability   |     | <input checked="" type="checkbox"/> |
| People highly dependent on medical care  |     | <input checked="" type="checkbox"/> |
| Minors without parental or guardian consent where they are the focus of the research   |     | <input checked="" type="checkbox"/> |
| People whose ability to give consent is impaired   |     | <input checked="" type="checkbox"/> |
| Resident of a custodial institution  |     | <input checked="" type="checkbox"/> |
| Unable to give free informed consent because of difficulties in understanding information statement (eg language difficulties) |     | <input checked="" type="checkbox"/> |
| Members of a socially identifiable group with special cultural or religious needs or political vulnerabilities                 |     | <input checked="" type="checkbox"/> |
| Those in dependent relationship with the researchers (eg lecturer/student, doctor/patient, teacher/pupil, professional/client) |     | <input checked="" type="checkbox"/> |
| Participants be able to be identified in any final report when specific consent for this has not been given                    |     | <input checked="" type="checkbox"/> |
| Indigenous Australians where Indigenous Australians are the focus of the research  |     | <input checked="" type="checkbox"/> |

## SECTION 8 - RESEARCH IN OVERSEAS SETTINGS. Does research involve any of the following?

1. It is important for Chief Investigators to ensure that they or the other researchers involved in the research have adequately addressed any research requirements of the countries in which their research is being undertaken.
2. A native speaking interpreter must verify Information Sheets provided in another language.

|  | YES | NO                                  |
|--|-----|-------------------------------------|
| Research being undertaken in a politically unstable area   |     | <input checked="" type="checkbox"/> |
| Research involving sensitive cultural issues   |     | <input checked="" type="checkbox"/> |
| Research in countries where criticism of government and institutions might put participants and/or researchers at risk |     | <input checked="" type="checkbox"/> |

## SECTION 9 – RESEARCH INVOLVING COMMERCIAL-IN-CONFIDENCE INFORMATION OR SENSITIVE POLITICAL/COMMERCIAL ISSUES

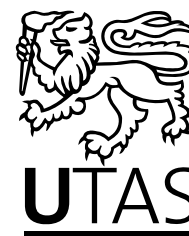
|   | YES | NO                                  |
|---|-----|-------------------------------------|
| Does your research explore potentially confidential business practices or seek to elicit potentially confidential commercial information from participants? |     | <input checked="" type="checkbox"/> |
| If you have answered 'YES', please describe how you will protect the confidentiality of each participant's information:                                     |     |                                     |
| Does your research explore potentially divergent political views, or involve the collection of politically sensitive information?                           |     | <input checked="" type="checkbox"/> |
| If you have answered 'YES', please describe how you will protect the confidentiality of each participant's information:                                     |     |                                     |

## CHECKLIST FOR MINIMAL RISK APPLICATIONS

Supporting documentation for your application is **ESSENTIAL**. Failure to attach relevant documentation may result in delays in the processing of your application.

Please ensure that the following documents are included with your application as necessary:

| Documents for Inclusion with Application   |                                     |
|--|-------------------------------------|
| Information sheet/s (if applicable)  | <input checked="" type="checkbox"/> |
| Consent form/s (if applicable)   | <input checked="" type="checkbox"/> |
| Questionnaires (if applicable)   | <input checked="" type="checkbox"/> |
| Interview schedules (if applicable)  |                                     |
| A copy of any permissions obtained i.e. Department of Education, Other Ethics Committees, Other Institutions (if applicable) |                                     |
| All documents relevant to the study, including all information provided to subjects.   |                                     |
| Telephone Preambles (if applicable)  |                                     |
| Recruitment Advertisements (if applicable)   |                                     |
| Draft of Emails to be sent to prospective participants (if applicable)   |                                     |



UNIVERSITY DEPARTMENT OF RURAL HEALTH

<Date>

## Information Sheet: Survey Questionnaire

**Title of Investigation:** Health and Well-being of Intermarried Filipino Women in Rural Tasmania.

### Name of Investigator:

This study is a part of PhD research project. The Chief Investigators are Dr. Quynh Le and Dr. Thao Le who are the supervisors of student investigator Chona Hannah.

We are writing to invite you to participate in a study about the health and wellbeing of intermarried Filipino women in rural Tasmania. Below is an outline of the study for your information.

### Purpose of the study

Intermarriage and the subsequent migration of Filipino women from the Philippines into Tasmania require great efforts of acculturation into the Australian society in general and into the rural areas of Tasmania in particular. There are successful cases but there are also cultural shocks and various problems facing Filipino wives in adapting and coping with personal, social and cultural problems. Thus, the main purpose of this research is to investigate the health and well-being of Filipino wives who came to Australia as a result of intermarriage and live in rural areas of Tasmania.

### Participant Benefit

Your participation in this research will give you some insights and benefits, as mentioned below:

- It will raise your awareness towards health and well-being issues and how you handle them.
- It will give you better understanding of dealing with the different cultural values, beliefs and practices in Tasmania as well as to the health care professionals.
- It will give you a realisation as how important it is to your health and wellbeing to properly access health care services.



UNIVERSITY DEPARTMENT OF RURAL HEALTH

## Study Procedures

Filipino female migrants who are married to Australian men will be invited to participate in a questionnaire and interview. The choice of the participant is based on:

- Their willingness to participate in the study
- The length of stay in Australia (new comers and have been here for 5 - 20 years)
- Their experiences as a wife of an Australian men and experiences in health and health care services

For recruiting their participation in this study, three main recruitment strategies will be used:

- Contact through the Filipino Association of Tasmania
- Contact through the Migrant Resource Centre in Tasmania
- Contact via snowball process that starts from an initial state of small significance and builds upon itself, becoming larger. For example, contact is made through a network of close friends who will introduce others.

Participation in this study involves fill in a survey questionnaire which will take about 15 - 30 minutes to complete. The survey questionnaire includes three parts: Part A is about personal background; Part B is all about health and wellbeing; Part three is any other comments to help the study. The questionnaire will be made available to the recruitment agencies with reply paid envelope. You can attach the questionnaire to this information sheet. Alternatively, we also provide a box to the recruiting agencies where you can drop the questionnaire as soon as you finish.

## Anonymity and confidentiality

You are not asked any identifying personal details in the survey questionnaire therefore the questionnaire is anonymous.

## Ethics Approval and Concerns/Complaints

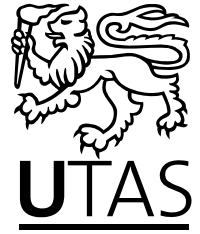
This study has received the approval of the Human Research Ethics Committee (Tasmania) Network

If you have any concerns or complaints of an ethical nature or complaints about the manner in which the project has been conducted, you may contact the Ethics Executive Officer of the Network (Tel: 03 - 6226 7479; Email: [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au)).

## Results of Investigation

- The copy of the study's result will be made available at the University Department of Rural Health.

Locked Bag 1372 Launceston  
Tasmania 7250 Australia  
Phone (03) 6324 4000 Fax (03) 6324 4040  
Email [Rural.Health@utas.edu.au](mailto:Rural.Health@utas.edu.au)  
Web [www.utas.edu.au/ruralhealth](http://www.utas.edu.au/ruralhealth)



UNIVERSITY DEPARTMENT OF RURAL HEALTH

- You will be given a copy of the information sheet to keep.

## Contacts

The researcher conducting the survey for this study is:

- Mrs. Chona Hannah

If you have any questions, or for further information, contact Dr. Quynh Le on (03) 6324 4053, email [Quynh.Le@utas.edu.au](mailto:Quynh.Le@utas.edu.au).

Thank you so much for taking the time to read this information sheet. Your participation is highly appreciated.

Yours sincerely,

Dr Quynh Le

Dr Thao Le

Chona Hannah

# Questionnaire

**Title:** Health and Well-being of Intermarried Filipino Women in Rural Tasmania

## Part 1: About you

Please put a tick in the appropriate box.

1. What is your age group?

- ☐ 24 and under
- ☐ 25-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65 and over

2. What is your highest level of education?

- ☐ Primary Education
- ☐ High School Education
- ☐ Vocational Education / TAFE
- ☐ Tertiary/University Education
- ☐ Other, please specify \_\_\_\_\_

3. What area in the Philippines you come from?

- ☐ Urban
- ☐ Rural
- ☐ Other (s) (please specify) \_\_\_\_\_

4. How long have you been living in Tasmania Australia?

- ☐ Less than 2 years
- ☐ 2 to 5 years
- ☐ Over 5 to 10 years
- ☐ Over 10 years

5. Which of the following best describes your employment status?

- ☐ Full time
- ☐ Part time
- ☐ Casual
- ☐ Not working

6. How would you describe your English competence?

- ☐ Excellent
- ☐ Good
- ☐ Just fine

- ☐ Poor  
☐ Very Poor

7. Please choose the range that best describes your combined household's income;

- ☐ Under \$20,000                      ☐ \$60,001 – 80,000  
☐ \$20,001 – 40,000                ☐ \$80,001 – 100,000  
☐ \$40,001 – 60,000                ☐ More than \$100,000

## Part 2: Health and wellbeing

Please circle only one scale for each item. Give the answer which best describes your views and attitudes toward health and health care services and wellbeing in rural Tasmania.

Strongly Agree (SA) = 5; Agree (A) = 4; Not Sure (NSu)=3; Disagree (D) = 2; Strongly Disagree (SD) = 1.

|  | SA | A | NSu | D | SD |
|--|----|---|-----|---|----|
| <b>Views on Health concept and well-being</b>  |    |   |     |   |    |
| 8. The absence of Filipino food choices affects my diet.                                       | 5  | 4 | 3   | 2 | 1  |
| 9. I still hold traditional Filipino beliefs /views about looking after my health.             | 5  | 4 | 3   | 2 | 1  |
| 10. I need to know more about building a healthy lifestyle in Tasmania.                        | 5  | 4 | 3   | 2 | 1  |
| 11. The changes of weather conditions affect my health.  | 5  | 4 | 3   | 2 | 1  |
| 12. Proper hygiene is a vital aspect for my health.  | 5  | 4 | 3   | 2 | 1  |
| 13. Religion or strong faith is considered as an important aspect in having good health.       | 5  | 4 | 3   | 2 | 1  |
| 14. Healthy lifestyle is vital to my wellbeing in Australia.                                   | 5  | 4 | 3   | 2 | 1  |
| 15. Proper nutrition is important for my health and wellbeing.                                 | 5  | 4 | 3   | 2 | 1  |
| 16. Physical health limits Filipino women's interaction with others.                           | 5  | 4 | 3   | 2 | 1  |
| 17. The care of my family is very important to me when I am sick.                              | 5  | 4 | 3   | 2 | 1  |
| 18. The Filipino community in Tasmania is important to my life in Tasmania.                    | 5  | 4 | 3   | 2 | 1  |
| <b>Access to health care services in Australia</b>   |    |   |     |   |    |
| 19. I was given booklet information about health care services in Australia when I migrated to | 5  | 4 | 3   | 2 | 1  |

Tasmania/Australia.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 20. Health care professionals are very approachable.   | 5 | 4 | 3 | 2 | 1 |
| 21. I can usually access health care services (such as, medical care, mental health care, community health care, etc.) when I need them. | 5 | 4 | 3 | 2 | 1 |
| 22. I prefer to be treated by a female doctor.   | 5 | 4 | 3 | 2 | 1 |
| 23. I learn about health care services through the mass media (TV, newspaper, magazine).   | 5 | 4 | 3 | 2 | 1 |
| 24. The Internet is helpful for my searching of information about health care services.  | 5 | 4 | 3 | 2 | 1 |

#### **Health care services for migrant**

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 25. Health care services in rural Tasmania don't have adequate facilities to cater for migrants' health.    | 5 | 4 | 3 | 2 | 1 |
| 26. Health care professionals should be aware of migrants' cultural views on health when dealing with them. | 5 | 4 | 3 | 2 | 1 |
| 27. Intermarried Filipino women face difficulties in accessing the health care services in rural Tasmania.  | 5 | 4 | 3 | 2 | 1 |
| 28. Information about health/health care services should be available in different languages.               | 5 | 4 | 3 | 2 | 1 |
| 29. There should be interpreting services available for migrants in any health care agencies.               | 5 | 4 | 3 | 2 | 1 |
| 30. Being able to speak English makes it easy for Filipino women to access health care services.            | 5 | 4 | 3 | 2 | 1 |

Please circle the scale which represents your best answer.

Excellent (E) = 5; Very Good (VG) = 4; Good (G) = 3; Fair (F) = 2; Poor (P) = 1.

| <b>Personal wellbeing in the acculturation</b>                                    | <b>E</b> | <b>VG</b> | <b>G</b> | <b>F</b> | <b>P</b> |
|---|----------|-----------|----------|----------|----------|
| <b>During your first two years in rural Tasmania, how satisfied are you with:</b> | 5        | 4         | 3        | 2        | 1        |
| 31. your life as a wife   | 5        | 4         | 3        | 2        | 1        |
| 32. your standard of living   | 5        | 4         | 3        | 2        | 1        |
| 33. your health   | 5        | 4         | 3        | 2        | 1        |
| 34. achievement in life   | 5        | 4         | 3        | 2        | 1        |

|                                   |   |   |   |   |   |
|-----------------------------------|---|---|---|---|---|
| 35. your personal relationship    | 5 | 4 | 3 | 2 | 1 |
| 36. how safe you feel             | 5 | 4 | 3 | 2 | 1 |
| 37. feeling part of the community | 5 | 4 | 3 | 2 | 1 |

**At present how satisfied are you with:**

|                                   |   |   |   |   |   |
|-----------------------------------|---|---|---|---|---|
| 38. your life as a wife           | 5 | 4 | 3 | 2 | 1 |
| 39. your standard of living       | 5 | 4 | 3 | 2 | 1 |
| 40. your health                   | 5 | 4 | 3 | 2 | 1 |
| 41. current achievement in life   | 5 | 4 | 3 | 2 | 1 |
| 42. your personal relationship    | 5 | 4 | 3 | 2 | 1 |
| 43. how safe you feel             | 5 | 4 | 3 | 2 | 1 |
| 44. feeling part of the community | 5 | 4 | 3 | 2 | 1 |

**General health and wellbeing:** Please circle the scale which represents your best answer.

Very Frequently (VF) = 5; Frequently (F) = 4; Occasionally (O) = 3; Rarely (R) = 2; Never (N) = 1.

|   | VF | F | O | R | N |
|---|----|---|---|---|---|
| 45. How often do you feel some body pains?              | 5  | 4 | 3 | 2 | 1 |
| 46. How often in a year you visit your family doctor?   | 5  | 4 | 3 | 2 | 1 |
| 47. How often in a year you need to see a dentist?      | 5  | 4 | 3 | 2 | 1 |
| 48. How often in a year you need to see an optician?    | 5  | 4 | 3 | 2 | 1 |
| 49. How often in a year you need to see a psychologist? | 5  | 4 | 3 | 2 | 1 |

50. Other comments .....

.....  
 .....  
 .....

Note: Your participation to this questionnaire is highly appreciated.

<Date>

## Information Sheet: Interview

**Title of Investigation:** Health and Well-being of Intermarried Filipino Women in Rural Tasmania

### Name of Investigator:

This study is a part of PhD research project. The Chief Investigators are Dr. Quynh Le, Associate Professor Sue Kilpatrick and Dr. Thao Le who are the supervisors of student investigator Chona Hannah.

We are writing to invite you to participate in a study about intermarried Filipino women in rural Tasmania. Below is an outline of the study for your information.

### Purpose of the study

Intermarriage and the subsequent migration by Filipino women from the Philippines into Tasmania require an effort of acculturation into the Australian society in general and into the rural areas of Tasmania in particular. There are successful cases and there are also cultural shocks and various problems facing Filipino wives in adapting and coping with personal, social and cultural issues. The main purpose of this research is to investigate the relationship between the health and wellbeing of Filipino wives and their access to and use of health care services in Tasmania.

### Participant Benefit

Your participation in this research will:

- Raise your awareness towards health and well-being issues and how you handle them, including giving you a better understanding of dealing with the different cultural values, beliefs and practices in Tasmania.
- Assist health care professionals in understanding the cultural differences in terms of expectations and behaviour between Filipino migrants and other rural Tasmanians

### Study Procedures

Filipino female migrants who are married to Australian men will be invited to participate in the interview. The selection of the participants is based on:

- Their willingness to participate in the study

## UNIVERSITY DEPARTMENT OF RURAL HEALTH

- The length of stay in Australia (up to ten years)

For recruiting their participation in this study, three main recruitment strategies will be used:

- Contact through the Filipino Association of Tasmania
- Contact through the Migrant Resource Centre
- Contact via snowball process that starts from an initial contact. For example, contact is made through a network of close friends who will introduce others.

Participation in this study involves a face to face interview which will take about an hour, at a place mutually convenient to yourself and the researcher. Phone interviews will be used if participants request it. The actual time and date will be finalized in consultation with you once the participant selection process has been made. The interview will be semi-structured with open-ended questions regarding issues of health and well-being of intermarried Filipino women.

With your permission, all interviews will be audio recorded. Copies of the transcription of the interview will be supplied to you upon request, and you may, if you wish, edit or modify what you earlier contributed for a period of one month after receiving the transcript.

Your participation in this study is entirely voluntary as evidenced by signing a Consent form. As sensitive cultural, personal and health issues may be raised; there is a small chance that the interview may cause a slight embarrassment. In any event, you may decline to answer any question, and may withdraw from the study at any time without any effect. Any data that you submitted during the interview may also be withdrawn at that time.

### **Anonymity and Confidentiality**

The researcher is obliged and responsible to keep your identity confidential and not disclose it, or make it identifiable in any publications or other research output. All the participants will have a code number like for example Intermarried Filipino women 01 without reference to your name. The data collected for this research will be stored on a CD and will be kept in a secure locked cabinet and secured password computer. Once the interview is completed, the audio data transcribed and analysed, the audio CDs and transcripts will be stored in a secure locked cabinet at the University for a period of 5 years after which they will be destroyed.

### **Ethics Approval and Concerns/Complaints**

This study has received the approval of the Human Research Ethics Committee (Tasmania) Network

If you have any concerns or complaints of an ethical nature or complaints about the manner in which the project has been conducted, you may contact the Executive Officer of the Network, Ms Nadia Mahjouri (Tel: 03 - 6226 7479; Email: [Nadia.Mahjouri@utas.edu.au](mailto:Nadia.Mahjouri@utas.edu.au)).



UNIVERSITY DEPARTMENT OF RURAL HEALTH

## Results of Investigation

- The summary result of the study will be made available on the University Department of Rural Health website for all the participants who would like to see the final result.
- You will be given a copy of the information sheet to keep.

## Contacts

The researcher conducting the survey for this study is:

- Mrs. Chona Hannah
- Phone: (03) 6344 4637
- Email: [channah@postoffice.utas.edu.au](mailto:channah@postoffice.utas.edu.au) or [paul.hannah@bigpond.com](mailto:paul.hannah@bigpond.com)

If you have any questions, or for further information, contact Dr. Quynh Le on (03) 6324 4053, email [Quynh.Le@utas.edu.au](mailto:Quynh.Le@utas.edu.au).

Thank you so much for taking the time to read this information sheet. Your participation is highly appreciated.

Yours sincerely,

Chief Investigators

Dr. Quynh Le

A/Prof Sue Kilpatrick

Dr Thao Le

# Interview Questions

1. When did you arrive in Australia?
2. How would you describe your first year in Tasmania?
  - Prompt: How different is Tasmanian culture from that of your place of origin?
  - How did you adapt to your life in the new culture?
3. What are your traditional views about health?
  - Prompt: What does being healthy mean to you?
  - How does your traditional view on health affect your health in a new cultural environment?
4. How is health important to your wellbeing in a new cultural environment?
  - Prompt: What are the major issues affecting your health and wellbeing that you have experienced in a new cultural environment?
  - How did you handle these issues?

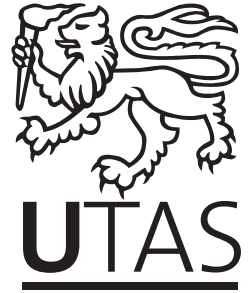
Before the researcher address the next set of questions, she is going to describe to the participant the different health care services in rural Tasmania and Australia in general.

5. What were your expectations of the health care services in Australia in general and in rural Tasmania in particular before and after you arrived in Australia?
  - What health care services did you access first?
  - Did anyone help you to access the health care services?
6. How important is social networking (e.g. family, friends and local communities) to you in terms of access to health care services and to your health and wellbeing in general?
  - How helpful was your husband's family in accessing health care services and to your wellbeing?
  - How does the Filipino community help you to have better health and wellbeing?
7. It is part of the Filipino culture to help and support their family wherever they are in the world. Do you and your husband openly discuss supporting your family back home?
  - Prompt: How does it affect your relationship as husband and wife?
8. What is the age gap between you and your husband?
  - How does this gap affect your relationship?
9. Do you and your husband have the same religion?
  - What is its implication to your life as a whole
10. As an intermarried Filipino woman or migrant, how do you describe your experiences in terms of accessing the health care services?
  - Prompt: How helpful was your experience for your health and wellbeing?
  - Can you please cite some instances or situations?

- What is the implication of these experiences to your life as a whole?

11. Is there anything else you would like to add or any suggestions about health and access to health care services?

Locked Bag 1372 Launceston  
Tasmania Australia 7250  
Telephone (03) 6324 4031  
Facsimile (03) 6324 4040  
Email rural.health@utas.edu.au  
Web www.utas.edu.au/ruralhealth



UNIVERSITY DEPARTMENT OF RURAL HEALTH

Date:

## CONSENT FORM

**Title of Project:** Health and Well-being of Intermarried Filipino Women in Rural Tasmania

1. I have read and understood the 'Information Sheet' for this study.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves an audio-taped and transcribed telephone or face-to-face interview of approximately one hour that will be audio recorded. I will be asked questions about my health and well-being, as well as my acculturation process in living in a new cultural environment. I am entitled to receive a copy of the audio file or transcript regarding the interview to edit or modify if I wish.
4. I understand that all research data will be securely stored on the University of Tasmania premises for a period of 5 years. The data will be destroyed at the end of 5 years.
5. Any questions that I have asked have been answered to my satisfaction.
6. I agree that research data gathered for the study may be published provided that I cannot be identified as a participant.
7. I understand that my identity will be kept confidential and that any information I supply to the researcher(s) will be used only for the purposes of the research.
8. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish may request that any data I have supplied to date be withdrawn from the research.

Name of participant: .....

Signature of participant: .....Date: .....

### Statement by Investigator

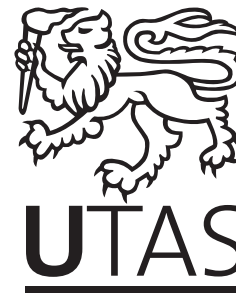
☐

The participant has received the Information Sheet in which my details have been provided so that participants have had opportunity to contact me prior to them consenting to participate in this project.

Name of Investigator: .....

Signature of Investigator: .....Date: .....

Locked Bag 1372 Launceston  
Tasmania Australia 7250  
Telephone (03) 6324 4031  
Facsimile (03) 6324 4040  
Email rural.health@utas.edu.au  
Web www.utas.edu.au/ruralhealth



UNIVERSITY DEPARTMENT OF RURAL HEALTH

Date:

## CONSENT FORM

**Title of Project:** Health and Well-being of Intermarried Filipino Women in Rural Tasmania

1. I have read and understood the 'Information Sheet' for this study.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves fill in a survey questionnaire which will take about 15-30 minutes to complete. The survey questionnaire includes three parts: Part A is about personal background; Part B is all about health and wellbeing; Part three is any other comments to help the study.
4. I understand that all research data will be securely stored on the University of Tasmania premises for a period of 5 years. The data will be destroyed at the end of 5 years.
4. Any questions that I have asked have been answered to my satisfaction.
5. I agree that research data gathered for the study may be published provided that I cannot be identified as a participant.
6. I understand that my identity will be kept confidential and that any information I supply to the researcher(s) will be used only for the purposes of the research.
7. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish may request that any data I have supplied to date be withdrawn from the research.

Name of participant: .....

Signature of participant: .....Date: .....

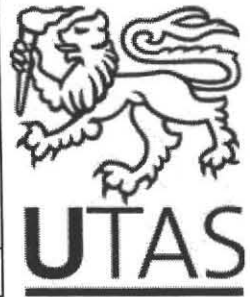
### Statement by Investigator

☐

The participant has received the Information Sheet in which my details have been provided so that participants have had opportunity to contact me prior to them consenting to participate in this project.

Name of Investigator: .....

Signature of Investigator: .....Date: .....



MEMORANDUM

<http://www.research.utas.edu.au/index.htm>

**HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK**

**MINIMAL RISK ETHICS APPLICATION APPROVAL**

15 April 2008

Dr Quynh Le  
Rural Health  
Private Bag 1372  
Launceston

**Ethics reference: H9912**

**'Health and well-being of inter-married Filipino women in rural Tasmania'.**

**PhD candidate: Chona Hannah**

Dear Dr Le

Acting on a mandate from the Tasmania Social Sciences HREC, the Chair of the committee considered and approved the above project on 8 April 2008.

All committees operating under the Human Research Ethics Committee (Tasmania) Network are registered and required to comply with the *National Statement on the Ethical Conduct in Research involving Humans 1999* (NHMRC guidelines).

Therefore, the Chief Investigator's responsibility is to ensure that:

- 1) All researchers listed on the application comply with HREC approved application.
- 2) Modifications to the application do not proceed until approval is obtained in writing from the HREC.
- 3) The confidentiality and anonymity of all research subjects is maintained at all times, except as required by law.
- 4) Clause 2.37 of the National Statement states:  
*An HREC shall, as a condition of approval of each protocol, require that researchers immediately report anything which might warrant review of ethical approval of the protocol, including:*
  - a) *Serious or unexpected adverse effects on participants;*
  - b) *Proposed changes in the application; and*
  - c) *Unforeseen events that might affect continued ethical acceptability of the project.*

The report must be lodged within 24 hours of the event to the Ethics Executive Officer who will report to the Chairs.

- 5) All participants must be provided with the current Information Sheet and Consent form as approved by the Ethics Committee.
- 6) The Committee is notified if any investigators are added to, or cease involvement with, the project.
- 7) This study has approval for four years contingent upon annual review. An *Annual Report* is to be provided on the anniversary date of your approval. Your first report is due [12 months from 'Ethics Committee Approval' date]. You will be sent a courtesy reminder by email closer to this due date.  
Clause 2.35 of the National Statement states:  
*As a minimum an HREC must require at regular periods, at least annually, reports from principal researchers on matters including:*
  - a) *Progress to date or outcome in case of completed research;*
  - b) *Maintenance and security of records;*
  - c) *Compliance with the approved protocol, and*
  - d) *Compliance with any conditions of approval.*
- 8) A *Final Report* and a copy of the published material, either in full or abstract, must be provided at the end of project.

Yours sincerely

*A. Knott*

*for* Ethics Executive Officer

Paper 1:

Hannah, C, 'Health and wellbeing of intermarried Filipino women, Graduate Research Papers in Rural Health, University of Tasmania, Quynh Le (ed), Launceston, pp. 65-82. (2007)

*Chona Hannah (100%)*

Paper 2:

Hannah, C. and Le, Q, 'Health and Wellbeing Issues Facing Intermarried Filipino Women in Rural Tasmania', Health and wellbeing: A social and cultural perspective, NOVA Science Publishers Inc, Quynh Le (ed), New York, pp. 173-184. (2011)

*Chona Hannah (60%), Quynh **Le** (40%)*

Paper 1 and Paper 2 from the Appendices have been removed for copyright or proprietary reasons